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THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 58, NO. 1 JANUARY, 1961 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

58
1961

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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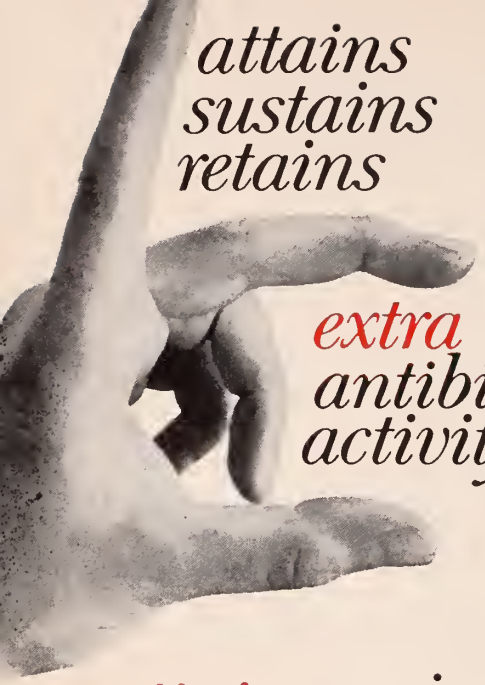
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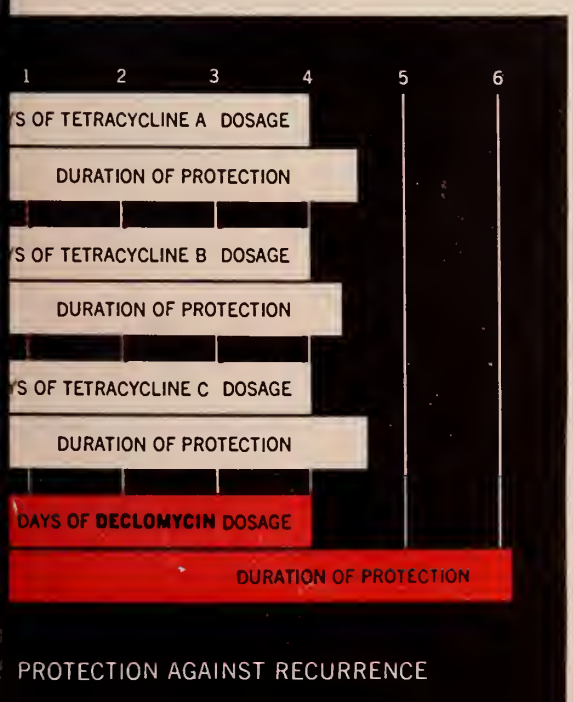


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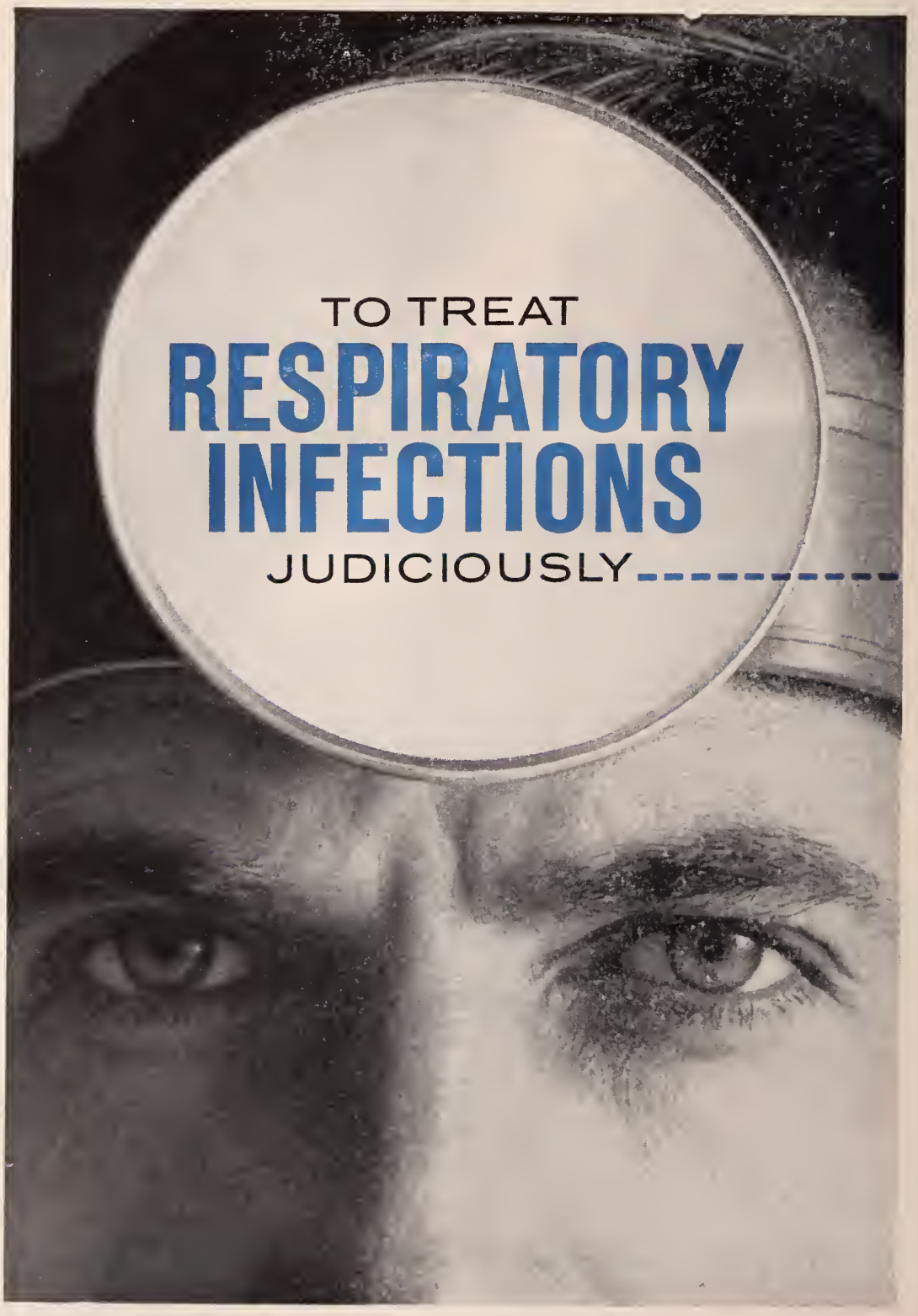
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(1) Bernstein, A. & Simon, F. "The treatment of Obesity in patients with Cardiovascular Diseases" Presented at Am. Coll. of Angiology meeting; June 12, 1960.

(2) Plotz, M.: Modern Management of Obesity, J.A.M.A. 170:1513-1515 (July 25) 1959.

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Source: Harrison, T. R., *et al.:* Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

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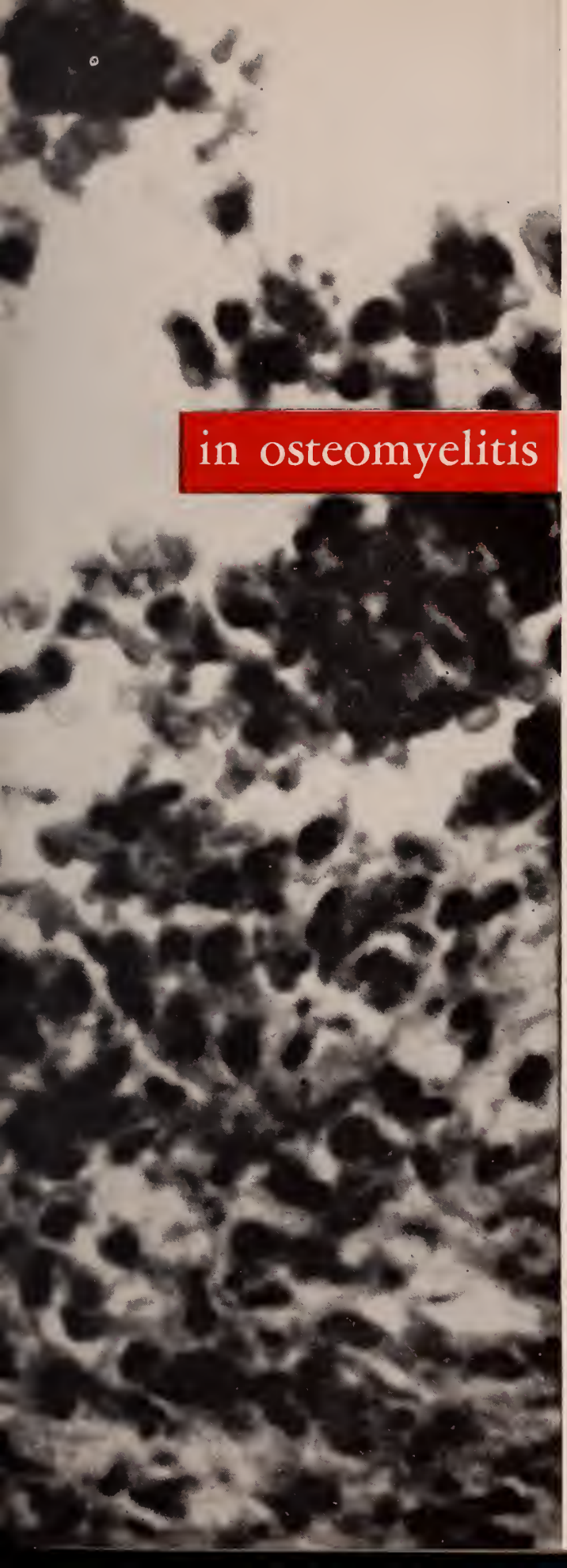
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Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Trademark, Reg. U. S. Pat. Off.

The Upjohn Company
Kalamazoo, Michigan

Upjohn

Panalba*

your broad-spectrum antibiotic of *first* resort



WHENEVER COUGH THERAPY
IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative | antihistamine
decongestant | expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Literature on request

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400



FIORINAL®

relieves pain, muscle spasm, nervous tension

rapid action • non-narcotic • economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

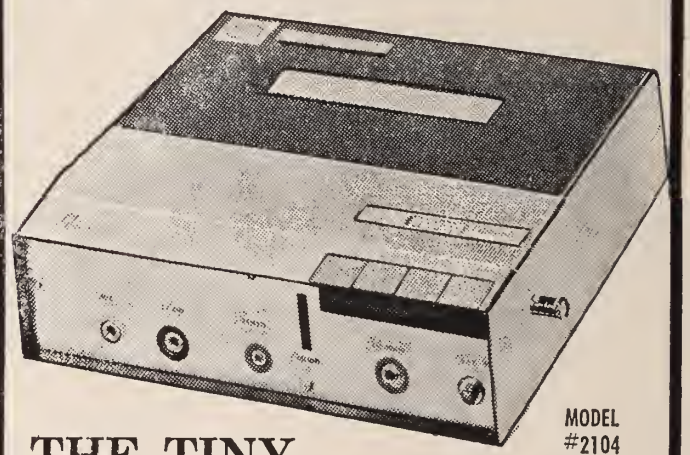
vailable: Fiorinal Tablets and
ew Form — Fiorinal Capsules

Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

SANDOZ

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THE TINY TAPE RECORDER WITH THE BIG PERFORMANCE!

So small it fits in the smallest briefcase with plenty of room left over! Wonderful for office, school or home, perfect as a gift that keeps on giving! Only 4½ pounds, 8" x 8" x 2½". Battery powered. Push Button controls. Two constant speeds, dual track; records and plays back one full hour on a 3" reel of tape. With mike, batteries and carrying strap. Gift Boxed.

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1¼ Grs. Ea.
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Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

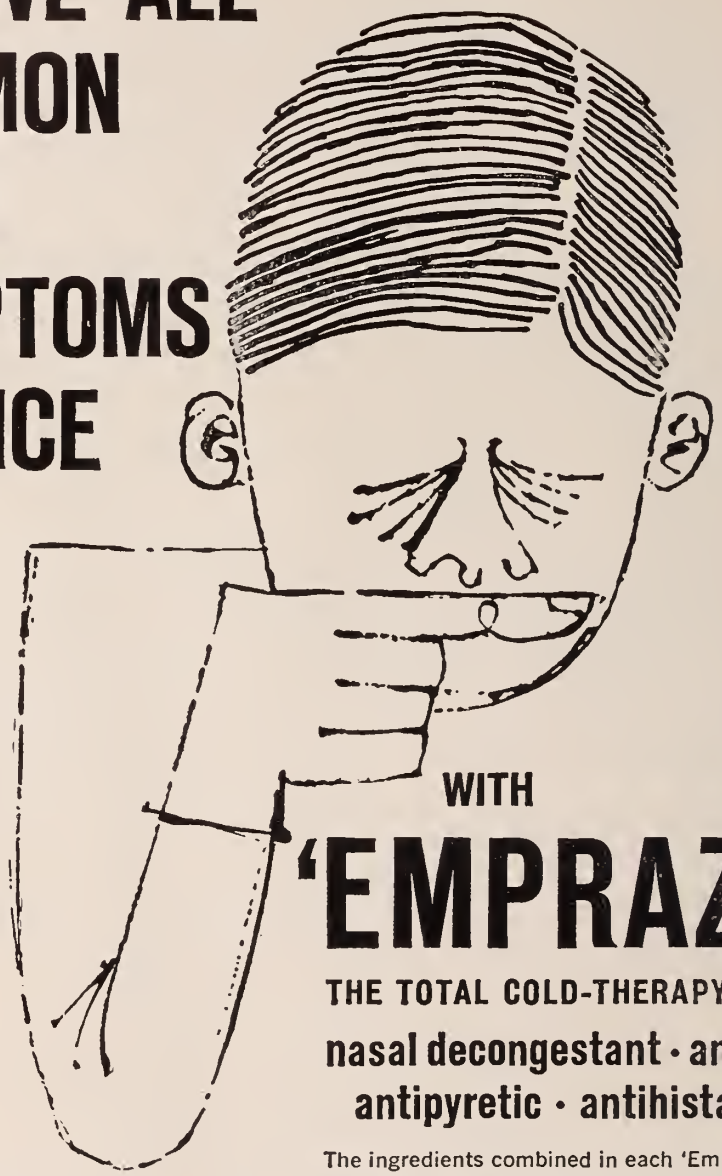
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New GRIP-TIGHT CAP for Children's Greater Protection



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

RELIEVE ALL COMMON COLD SYMPTOMS AT ONCE



WITH

'EMPRAZIL'®

THE TOTAL COLD-THERAPY TABLET

nasal decongestant · analgesic antipyretic · antihistamine

The ingredients combined in each 'Emprazil' tablet provide multiple drug action for prompt symptomatic relief of aches, pains, fever and respiratory congestion—due to common colds, flu or grippe—without gastric irritation.

Dosage: Adults and older children—One or two tablets t.i.d. as required. Children 6 to 12 years of age—One tablet t.i.d. as required.

Supplied: Bottles of 100 or 1000

Each orange and yellow layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

Complete literature available on request.

BURROUGHS WELLCOME & CO.
(U.S.A.) INC., Tuckahoe, N. Y.

NEW FILM ON DEPRESSIONS



he diagnosis and treatment of

DEPRESSIONS *in private practice*

Prepared and narrated by S. Bernard Wortis, M.D., Dean of the School of Medicine and Post-Graduate Medical School, Chairman and Professor of the Department of Neurology and Psychiatry, New York University Medical Center

This timely teaching film is now available for showing to interested professional groups.

The film describes and illustrates the signs of depressions commonly seen in general medical practice, and outlines suggested plans of treatment by the family physician. Suggestions are given on methods of handling suicide risk, referral, treatment in consultation, and hospitalization.

The film is black and white, sound-on-film, runs about 20 minutes and contains no commercial material.

To arrange for a group showing, please write the date you wish to show the film (list alternate dates, if possible) and the number of physicians expected to attend.

Mail your request to:

Professional Services Dept.
WALLACE LABORATORIES
Cranbury, N. J.

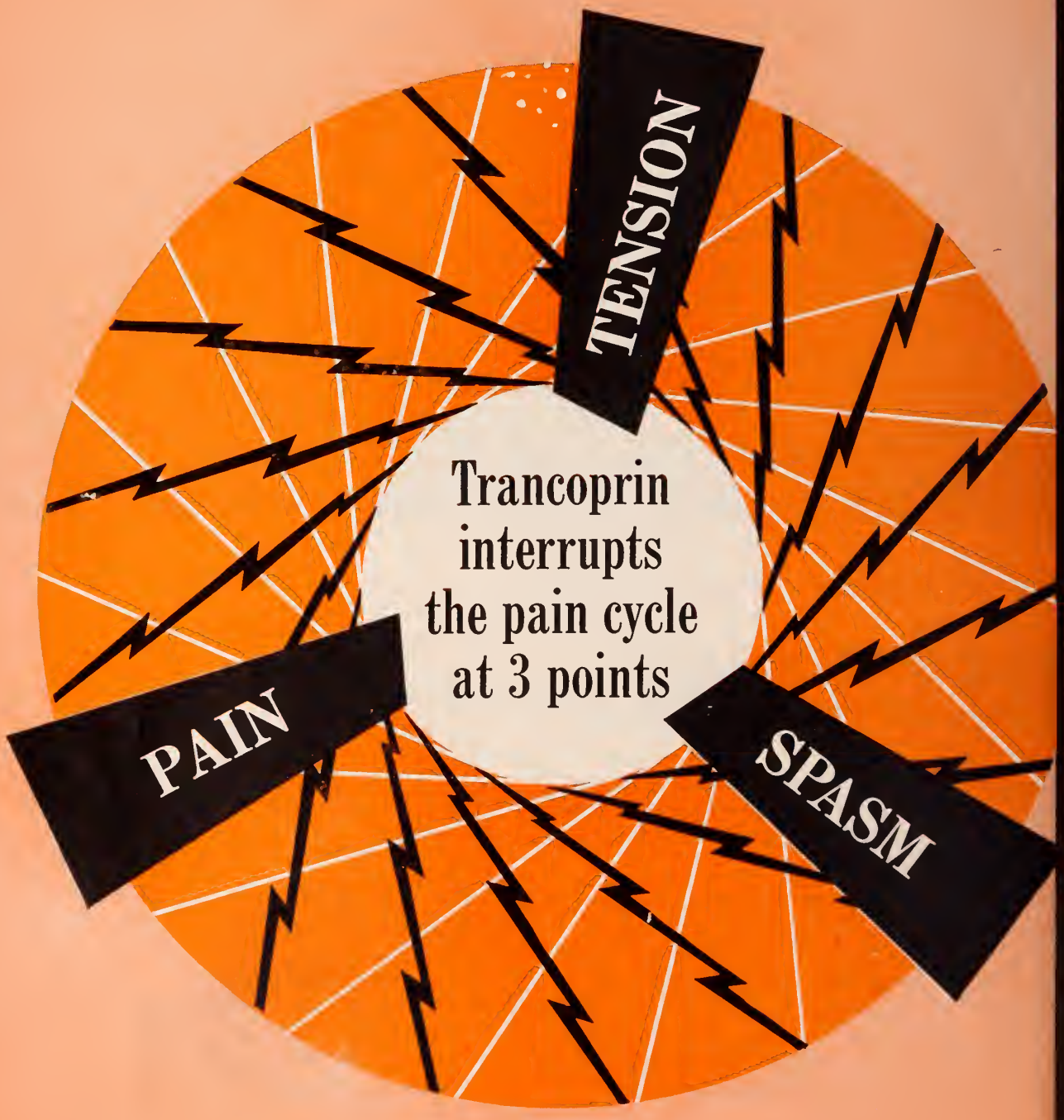
WALLACE LABORATORIES / *Cranbury, N. J. / producers of Deprol®*

announcing...

Trancoprin

acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / **non-narcotic analgesic**

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.



chronic leg ulcer?

"many patients who had ulcers  from one to eight years obtained complete healing in six to ten weeks."[1]



CHLORESIUM®

ointment

CHLORESIUM Ointment has long been recognized as a medication of choice for local treatment of chronic wounds and ulcerations.[1,2] This time-tested agent is noted for its ability to promote healthy granulation, encourage normal epithelization, relieve pain and inflammation, and deodorize malodorous lesions. Furthermore, a complete lack of irritating or sensitizing properties makes CHLORESIUM ideal for patient-use at home.

CHLORESIUM Ointment—0.5% water-soluble chlorophyll derivatives in a hydrophilic ointment base, in 1-oz. and 4-oz. tubes.

CHLORESIUM Solution—0.2% water-soluble chlorophyll derivatives in isotonic saline solution, in 2-oz. and 8-oz. bottles.

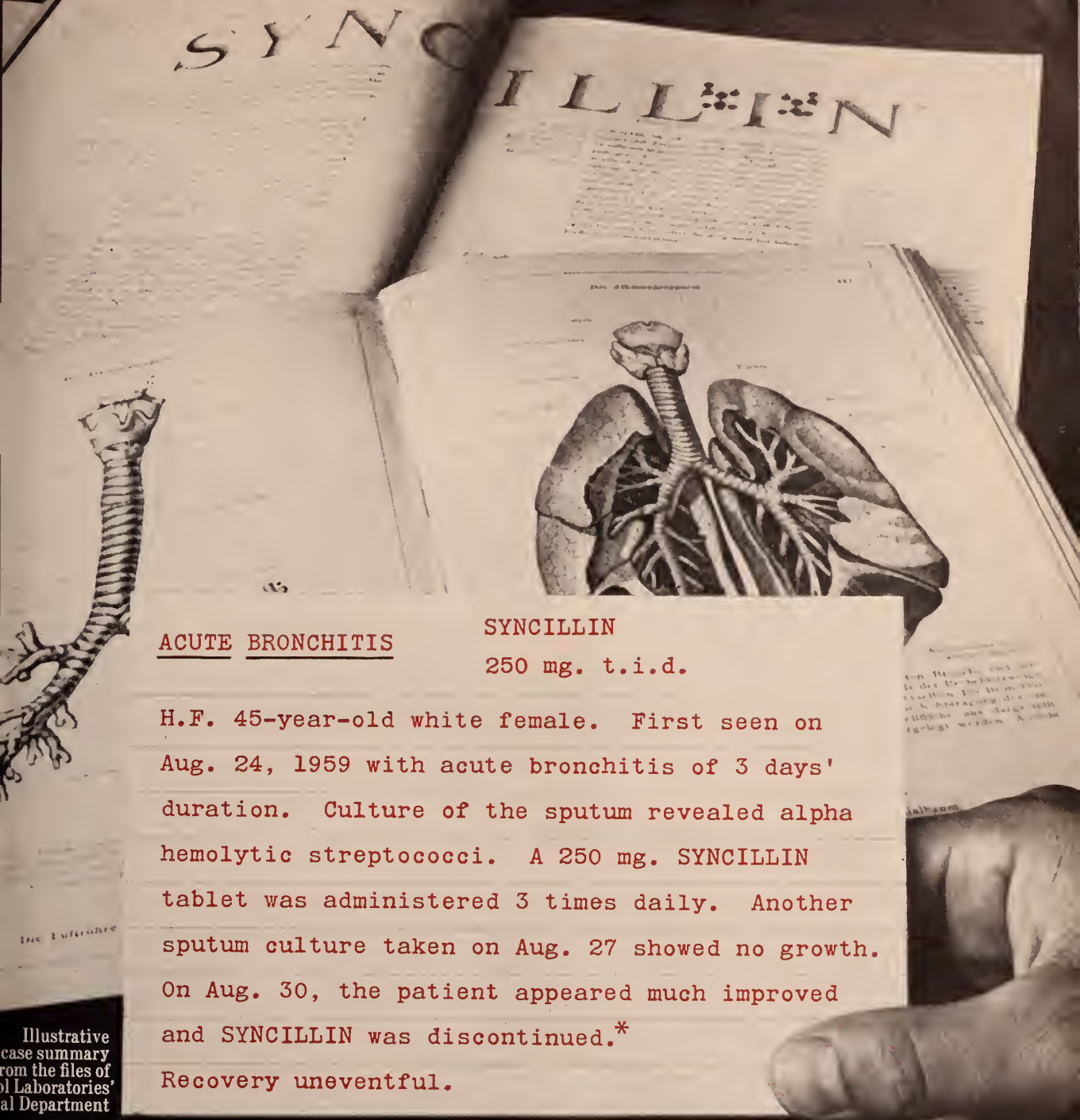
(1) Boehme, E. J.: Lahey Clin. Bull. **4**:242, 1946. (2) Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Samples and literature available on request

Rystan

Mount Vernon, N.Y.

34760



ACUTE BRONCHITIS

SYNCILLIN
250 mg. t.i.d.

H.F. 45-year-old white female. First seen on Aug. 24, 1959 with acute bronchitis of 3 days' duration. Culture of the sputum revealed alpha hemolytic streptococci. A 250 mg. SYNCILLIN tablet was administered 3 times daily. Another sputum culture taken on Aug. 27 showed no growth. On Aug. 30, the patient appeared much improved and SYNCILLIN was discontinued.*
Recovery uneventful.

Illustrative case summary rom the files of ol Laboratories' al Department

THE ORIGINAL phenethicillin

SYNCILLIN®

(phenoxyethyl penicillin potassium)

IRST SYNTHESIZED AND MADE AVAILABLE BY BRISTOL LABORATORIES

dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:
yncillin Tablets—250 mg. (400,000 units)... Syncillin Tablets—125 mg. (200,000 units)
yncillin for Oral Solution—60 ml. bottles—when reconstituted, 125 mg. (200,000 units) per 5 ml.
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treptococcal infections should be treated for at least 10 days to prevent the development of rheumatic fever nd as prophylaxis against bacterial endocarditis in susceptible patients.

mplete information on indications, sage and precautions is included in the

BRISTOL LABORATORIES, Div. of Bristol-Myers Co., SYRACUSE, N.Y.

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for relief of hypertension

RUHEXATAL WITH RESERPINE

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Rapid and Prolonged

BLOOD PRESSURE REDUCTION

RELIEF OF ANXIETY AND TENSION

Protection Against

CAPILLARY FRAGILITY

A therapeutic combination providing a safe, effective, long range treatment of hypertension with minimal side effects high patient acceptance and economy.

Each tablet contains Reserpine 0.1 mg.
Mannitol Hexanitrate 30 mg. Rutin 20 mg.
Ascorbic Acid 10 mg.

LEMMON PHARMACAL CO. SELLERSVILLE, PA.



if you're treating a coccal infection...

you can't prescribe a more effective antibiotic than ERYTHROCIN

Erythromycin, Abbott

How much "spectrum" do you need in treating an infection? Clearly, you want an antibiotic that will show the greatest activity against the offending organism, *and the least activity against non-pathogenic gastro-intestinal flora.*

Weigh these criteria—and make this comparison—when treating your next coccal infection. Erythrocin is a medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections—*which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

ABBOTT

"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the diuretic of choice in edema and hypertension. It maintains a favorable urinary sodium-potassium excretion ratio, retains a balanced electrolyte pattern, and causes a relatively small increase in the urinary pH.[2] More potent than other diuretics, Naturetin usually provides 18-hour diuretic action with just a single 5 mg. tablet per day — economical, once-a-day dosage for the patient. Naturetin c̄ K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term therapy.

Supplied: Naturetin Tablets, 5 mg., scored, and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets, capsule-shaped, containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets, capsule-shaped, containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride. For complete information consult package circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

Naturetin Squibb Benzydroflumethiazide

Naturetin c̄ K Squibb Benzydroflumethiazide with Potassium Chloride

SQUIBB



NATURETIN® IS A SQUIBB TRADEMARK

Your difficult rheumatic patient...

on the job again

through effective relief and rehabilitati



For the patient who requires steroids

PABALATE®-HC

(PABALATE WITH HYDROCORTISONE)

Comprehensive synergistic combination of steroid and nonsteroid antirheumatics... full hormone effects on low hormone dosage... satisfactory remission of rheumatic symptoms in 85% of patients tested.

In each enteric-coated tablet:

Hydrocortisone (alcohol)	2.5 mg.
Potassium salicylate	0.3 Gm.
Potassium para-aminobenzoate	0.3 Gm.
Ascorbic acid	50.0 mg.

or the patient who does not require steroids

PABALATE®

eciprocally acting nonsteroid antirheumatics... more ffective than salicylate alone.

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odium para-aminobenzoate	0.3 Gm. (5 gr.)
scorbic acid	50.0 mg.

or for the patient who should avoid sodium

PABALATE®-Sodium Free

Pabalate, with sodium salts replaced by potassium salts.

In each enteric-coated tablet:

Potassium salicylate	0.3 Gm. (5 gr.)
Potassium para-aminobenzoate	0.3 Gm. (5 gr.)
Ascorbic acid	50.0 mg.

PABALATE® Robins PABALATE®-HC

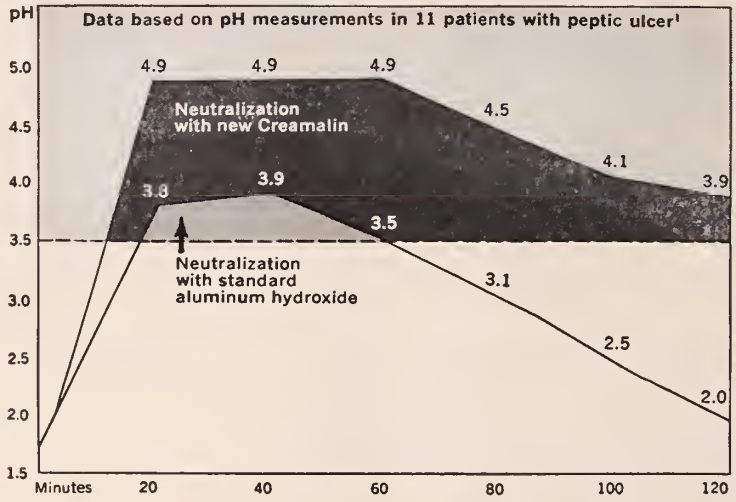
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At the site of peptic ulcer



Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

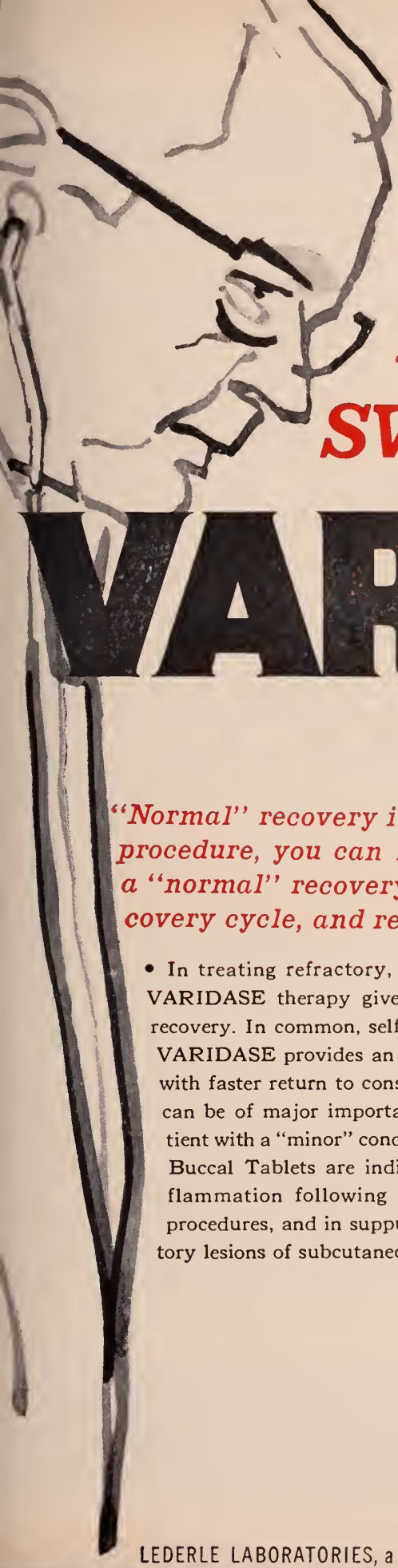
Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

1467M



do all you can whenever there is local inflammation/ swelling/pain...

VARIDASE

STREPTOKINASE-STREPTODORNASE LEDERL

buccal tablets

"Normal" recovery is not enough. Now, by adding VARIDASE to you procedure, you can release your patient from the stress and pain o a "normal" recovery—put comfort in convalescence, shorten the re covery cycle, and reap the reward of greater patient appreciation.

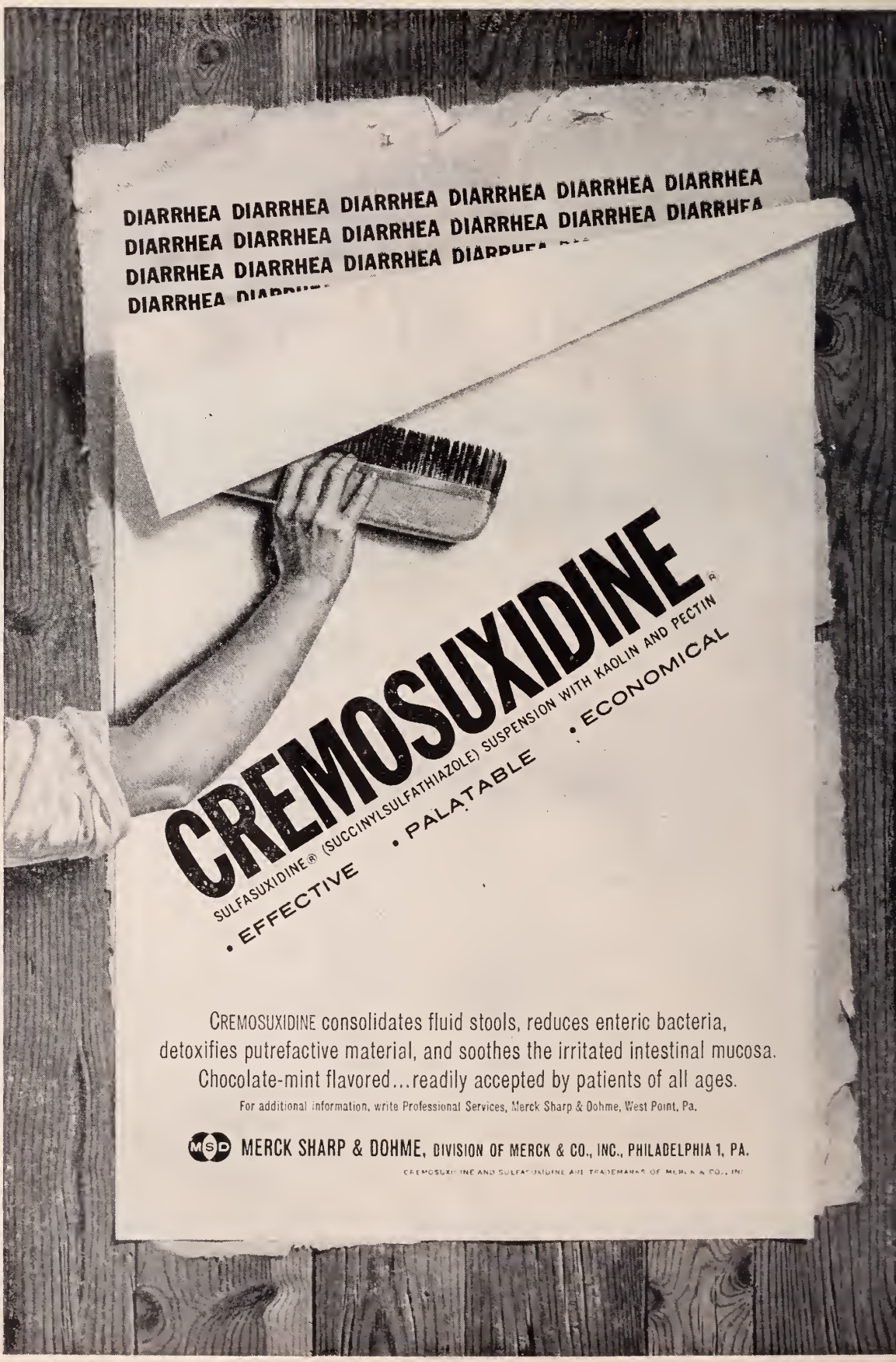
• In treating refractory, chronic conditions, VARIDASE therapy gives added impetus to recovery. In common, self-limiting conditions, VARIDASE provides an easier convalescence with faster return to constructive living. This can be of major importance even to the patient with a "minor" condition. • VARIDASE Buccal Tablets are indicated to control inflammation following trauma or surgical procedures, and in suppurative or inflammatory lesions of subcutaneous and deep tissues.

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• Supplied: *Each tablet contains 10,000 Uni Streptokinase, 2,500 Units Streptodornase. Box of 24 and 100 Tablets.*

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CREMOSUXIDINE consolidates fluid stools, reduces enteric bacteria, detoxifies putrefactive material, and soothes the irritated intestinal mucosa. Chocolate-mint flavored...readily accepted by patients of all ages.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

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CREMOSUXIDINE AND SULFASUXIDINE ARE TRADEMARKS OF MERCK & CO., INC.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity—and fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

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BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
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PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

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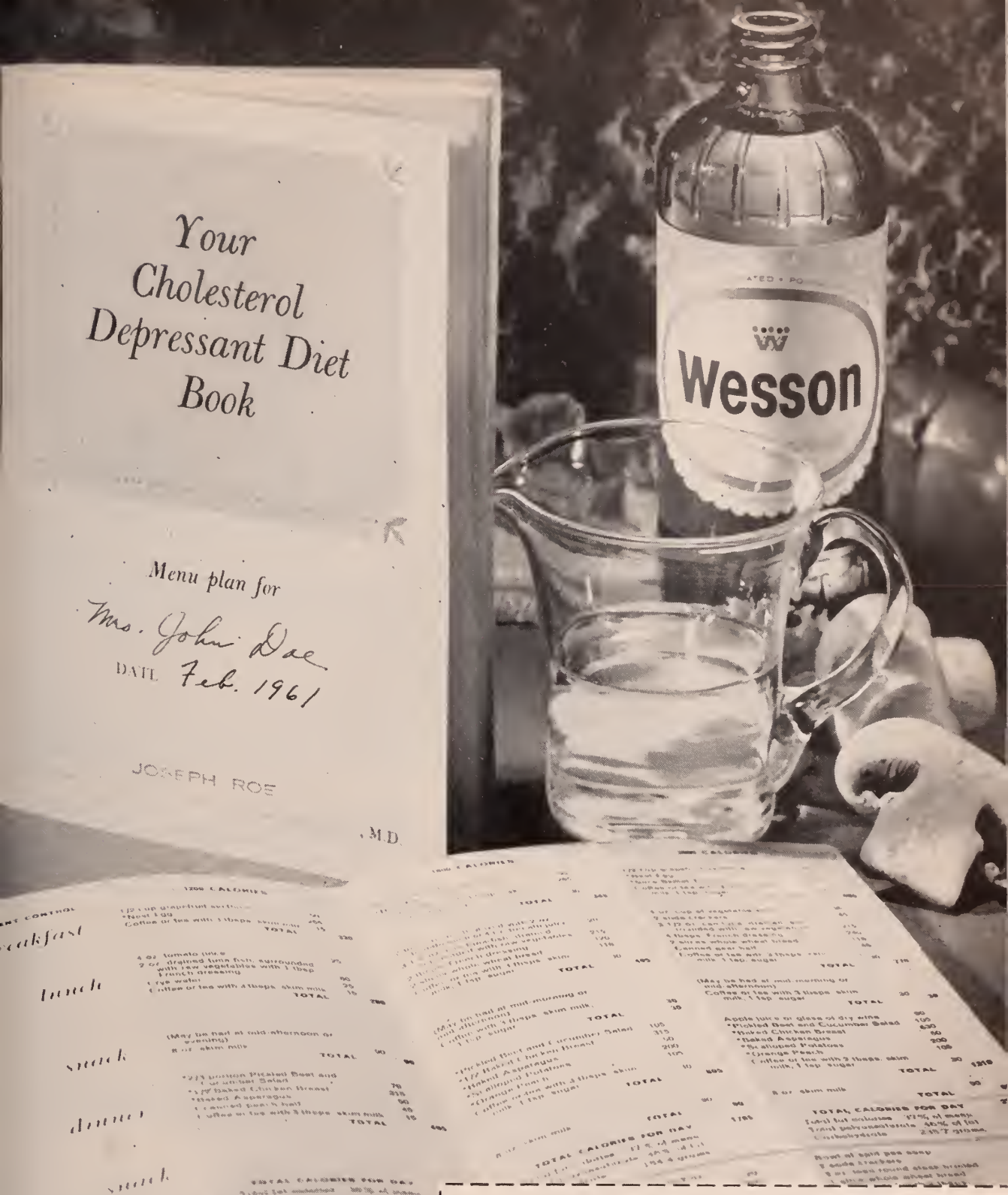
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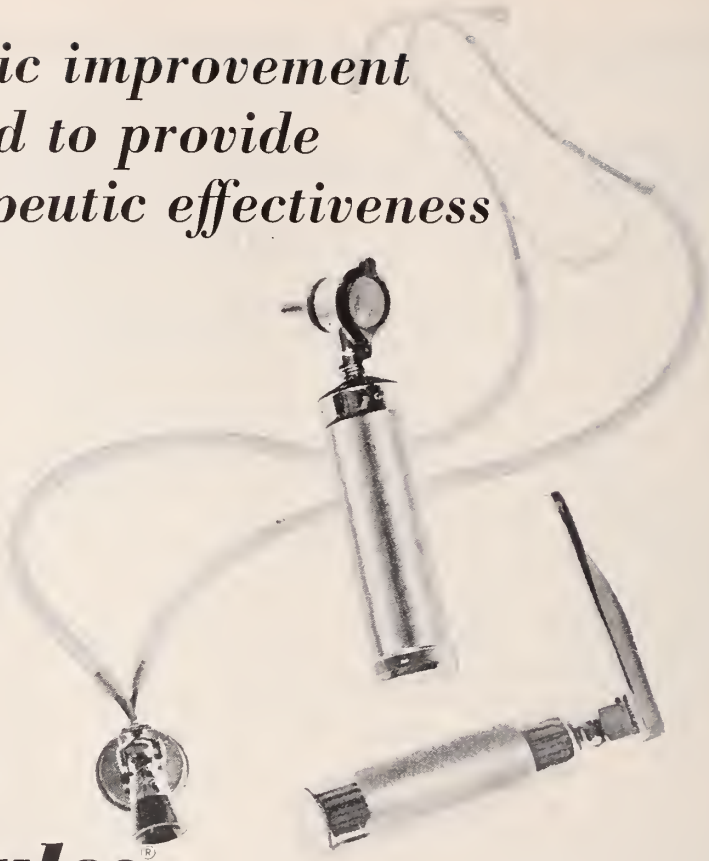
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1. Stephens, V. C., *et al.*: J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
2. Salitsky, S., *et al.*: Antibiotics Annual, p. 893, 1959-1960.
3. Reichelderfer, T. E., *et al.*: Antibiotics Annual, p. 899, 1959-1960.
4. Kuder, H. V.: Clin. Pharmacol. & Therap., in press.

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Editorials • • •

The Hospitals Face the Sixties

It sounds like something out of Buck Rogers, sired by H. G. Wells—these images of the hospital of the future. No, we are not talking of cost of hospitalization or Blue Cross premiums. That's tomorrow's problem. It's the day after tomorrow that enchants us now. Furthermore, the dream on which we will now enlighten you, may be realized sooner than you think. And right in New Jersey, too.

Architecturally, it is simple. The hospital will be built underground, and all you will see from the air will be a few elevater shafts and ventilating tubes. Thus, the parking lot will dominate the hospital—which in this automobile age seems fair enough. As for the patient—well, he will be anesthetized on admission and will wake up with all his symptoms gone. As Wheeler [1] says, "No bother, no worry, no complaints, no noise, no visitors, no incompatible room-mates." If the patient has an infection, he will be treated in a sealed-in antiseptic unit, untouched by human hands. Indeed, Mr. Wheeler even visualizes a system where all health services will be rendered at a few concentrated points—a mere dozen in the whole country—to which patients (completely anesthetized) will be sent through pneumatic tubes. Then, warming to the subject, he foresees electronic machines which will digest the symptoms fed to it on punched tape, and come up with a treatment program; or he can be treated in a special chair with attachments to simulate peristalsis, dispose of waste products (how delicately he phrases this!), and measure pulse and temperature. Indeed, elec-

1 Wheeler, E. Todd: *Hospital Topics*, June 1960.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 677

VOL. 58, NO. 1 JANUARY, 1961 Subscriptions, $3.00 per Year
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tro-encephalographic and electrocardiographic monitoring can be continuous in this magnificent electric chair.

But tighten your seat belts, doctor. This is no pipe dream. Something very much like this is planned for a New Jersey hospital in the next few years. Radcliffe [2] described plans for the Columbus Hospital in Newark. "We will today build the hospital of tomorrow" is their slogan, and it sounds as if they mean it. "We reason" says Mr. Radcliffe, logically enough, "that if animals a hundred miles in the air can be monitored, there is no reason why such monitoring cannot be done in a hospital a few feet away."

Among the mechanisms dreamed of for the new Columbus Hospital are automatic drug dispensers on each ward (looking like cigarette vending machines) that not only fill the doctor's order, but also send an impulse to the accountant so that the charge may appear on the patient's bill. Television tape recorders will store fluoroscopic examinations, thus making a permanent record of what is now only a fleeting image. An electronic computor will provide the physician with a detailed record of the patient's progress. "It will," says Mr. Radcliffe, "give a doctor a similar orientation to that which the banker derives from observing the stock exchange trend on a tape."

In the operating room, the patient will be wired to gadgets which will record respiration, heart sounds, rectal temperature, systolic blood pressure, electrocardiographic tracing and skin temperature. An alarm will call attention to any morbid fluctuation in these modalities. When the patient gets to the recovery room, the wiring goes with him, as the recovery room will have plugs and outlets too.

Under study is a device to be clamped into the patient which will record every four hours his temperature, pulse and blood pressure. This machine will disgorge an adhesive-backed record which will be attached (automatically, we presume) to the patient's chart. This, Mr. Radcliffe estimates, will save one hour of nursing time per patient per day. In a 400-bed hospital this will save a half a million hours of nursing time a year and—well, you figure it out.

"We plan," says the article "to make extensive use of closed circuit television for visual monitoring. Our blue-print calls for automatic scanners at each nurses' station." Another part of the Columbus Hospital project is "to install recreation panels in the walls. Each panel will have television, piped music, and FM radio." (It seems only fitting that the hospital is named for the great Discoverer).

Gastro-intestinal motility will be measured by an ingestible (but, one hopes, indigestible) "pressure transensor" containing a tiny nickel bellows. This will enable the observer to study intestinal motility for five days. In the maternity wing, a machine will register the time between the moment of birth and the first breath. All automatically.

A recent article in an engineering journal [3] adds some more details of the hospitals of the seventies. In Montgomery, Alabama, for instance, a hospital will be built under a plastic dome, "linking medicine, electronics and automation." One innovation will be a sterile polyethylene bag which will drop over the bed and permit the surgeon to operate right there —no more operating rooms. But it won't be an ordinary bed. It will be piped for a flush toilet, a shower and a wash basin; wired for television, physiologic monitoring and passive exercises—a home away from home in a ten-foot box. Patients will wear rings on their fingers (and, we suppose, bells on their toes) which will signal to nurses' stations any change in pulse, blood pressure and so on. The hospital will be run from a master switchboard something, one guesses, like a modern freight-yard. Behind each bed will be a locker which will be a food freezer containing each meal for a week or so in advance. A flip of the switch (perhaps flipped by automation) will convert the freezer into a cooker, and produce a meal at a time.

"Of course," the author generously concedes, "it will be a number of years before

2. Radcliffe, George: Physiologic Monitoring in a General Hospital. *Transactions of the New York Academy of Sciences*, 23:1 (Oct. 11, 1960).

3. *Engineering News Record* staff-article, June 16, 1960.

the kinks are worked out." A side effect of all this, is that hospital personnel will then have more time for tender, loving care . . . care of the patient, that is.

One final note which, somehow, seems appropriate even though Christmas has come and gone. Our State Department of Institutions and Agencies has announced that henceforth only artificial Christmas trees may be used in state institutions. Natural trees, they say, are fire hazards. The plastic trees can be re-used each year, thus saving a lot of money.

Well, as Carlyle said, "All things wax and roll onwards. Nothing is ever completed. Everything is moving towards completion, but never arriving."

Medicine and the Challenge of the New Year

Every new year is an unwritten page—a hope, a challenge. In 1961, the problem will be to improve public support for the profession and to show that we have the imagination and flexibility to meet new problems. The public will not challenge us in terms of scientific medical advances. They take such progress for granted.

It is in the field of medical economics and the distribution of medical care that our 1961 challenge lies. This is reminiscent. Some 20 years ago we responded to an urgent medico-economic challenge. In doing so, we showed that doctors—working together with labor, industry and community leaders—could solve a great social problem by voluntary effort.

The challenge we faced in 1940 was the threat of universal compulsory health insurance, which many people then thought was the only feasible solution to the problem of prepayment for modern medical care.

Medicine's response was the creation of Blue Shield, through which our profession acknowledged its responsibility to provide good medical care and to help people pay for it when they need it. Blue Shield was the pacesetter of the vast voluntary medical prepayment system. Our efforts were soon supplemented by the private insurance industry, which today underwrites about as much medical care insurance as do all our Blue Shield Plans.

Now—in 1961—we face a new challenge in the proposal to utilize the Social Security System to underwrite medical care for its aged beneficiaries. Many fear that this would be preliminary to the extension of medical care coverage through Social Security to the entire population.

How can medicine meet this new challenge? Why not look again to Blue Shield, medicine's own prepayment mechanism? Blue Shield today has earned a vote of confidence from more than 45 million citizens and it also enjoys substantial—though not uncritical—support from much of labor and industry.

Our local Blue Shield programs vary widely in scope of coverage, in the degree of assurance of full payment that they offer the patient, and in the adequacy of their payments to physicians. Our New Jersey Plan is a good one.

To meet the challenge of 1961 and keep our patients and our profession free of political domination, we must make every one of our Blue Shield Plans as good as the best of them. If we fail to give all the people of America the very best medical prepayment program we can possibly offer them, they may look elsewhere for the answer to this challenge.

Original Articles • • •

Irving Willner, M.D.
Newark

Changing Problems in Tuberculosis Control

Dr. Willner believes that tuberculin testing is better than mass x-ray surveys for a tuberculosis program. In spite of new drugs, a control problem is still with us.

Progress in anti-tuberculosis therapy and experience in case finding require changes in control procedure. Time tested methods remain fundamentally the same and cannot be discarded. Locating new patients and supervising the known active cases demands a changing program. Eradication of the disease is being frequently discussed in spite of the fact that new patients are being located almost daily.

Prior to modern chemotherapy, treatment of pulmonary tuberculosis depended largely on bed rest, nutrition and pneumothorax. Most patients were either in sanatoria or under the care of specialists in pulmonary diseases. The physician now specializing in tuberculosis is a rarity. The advent of streptomycin followed by PAS, isoniazid and other anti-tuberculosis drugs, so simplified treatment that patients could be managed by the family physician. This has resulted in fewer cases being referred for hospitalization, and in an increase in the number of ambulatory patients. The unhospitalized have become a major health problem. Often, those with active lesions and positive sputa are permitted to follow their usual routine and activity. The previous difficulty of controlling the "good chronic" with lingering tuberculosis and a positive sputum, has been complicated by the group under ambulatory therapy, as an added source of infection.

Over the years there has been a gradual drop in the death rate in tuberculosis, and following the use of streptomycin, the most rapid decrease in mortality in history. Although deaths will continue to fall, eradication is still a long way off. Newark (N.J.) in 1915 had a death rate of 195 per hundred thousand population. This rate gradually declined and in 1944 (prior to the use of streptomycin) reached 60 per hundred thousand. Then followed the rapid drop to 11.6 in 1958, the lowest in the history of the city. The same rate was maintained in 1959. This spectacular fall occurred with a disease that continues to take a greater toll of health and life than any other communicable ailment and with a destruction greater than all other communicable diseases combined. Once a problem of young adults, it now concerns the aged, especially old men.

Morbidity has also been declining but the drop does not parallel the mortality rate. New drugs and new surgical procedures account for the sharp drop in the death rate. The case rate has been falling much more slowly. In 1915, the morbidity rate in Newark was 518 per hundred thousand population. This declined to 112 in 1944; to 90 in 1958; and to 82 in 1959. The falling death and case rates may lead to the impression that tuberculosis is becoming a minor issue. With a disease charac-

terized by chronicity and relapses, the arrested case can flare into activity. Apparently healed and inactive cases can still harbor active tubercle bacilli, which can again spread, causing infiltration and cavitation. Modern chemotherapy, while saving lives, is also building up a reservoir of active and inactive cases that must be constantly followed. Drugs have not been controlling in all cases. Some have reactivated, some have developed resistance against one or more of the drugs, and in others that have been infected with drug resistant bacilli, chemotherapy has been of little or no value.

Case finding is essential in any public health program, and depends largely on x-ray surveys in adults, and tuberculin testing in children.

Mass x-ray surveys have been utilized on a voluntary basis for years. Efforts are made to attract to the mobile and stationary units individuals most likely to harbor tubercle bacilli. Some, knowing or suspecting they have tuberculosis, avoid the surveys. They do not want to be known to health authorities. Only a small proportion of the population is x-rayed and only a few (less than 1 in 1,000) active cases that are not known to the Health Department, are found. Publicity in the press as to the dangers of radiation exposure has also affected the response to these projects. In recent years, the campaigns have been conducted only in the high incidence areas where statistics demonstrate tuberculosis is present. All contacts of known patients must be routinely x-rayed. The Newark City Dispensary for over 20 years has x-rayed all new applicants for clinical care, regardless of complaints or diagnosis. Radiographing all hospital admissions has been recommended for many years. Experience has demonstrated that eight times as many cases can be located by this method as compared with drives among the general public. Results hoped for with mass x-ray surveys, have not materialized. Those who have annually returned to have their lungs filmed were the least likely to develop the disease. As a case finding procedure, surveys have been expensive, and when an occasional case is located, it is usually in a moderately or far advanced stage.

Tuberculin testing is the best diagnostic tool for determining infection by the tubercle bacillus. Those surveys are economical and will furnish information as to infection long before symptoms appear, or x-rays show any pathology. The stronger the reaction, the more the possibility of disease. Reactors must be followed with chest x-rays well into adult life. All members of the family and contacts must be examined and x-rayed in the hunt for the source of infection. Only a small per cent of the reactors will develop active disease, and often a long time elapses between the reaction and the beginning of clinical tuberculosis. Tuberculin testing should be repeated annually, and more often among those who have been in contact with an active case of tuberculosis. On routine testing, the time of infection can be estimated when a persistently negative reactor changes to positive. Recent converters and reactors under 3 years of age should be given isoniazid therapy. There has been a remarkable decline in the number of reactors among children at the Newark Board of Health over a period of 20 years, when survey records demonstrate a decline from 47 to 12 per cent. Tuberculin testing assumes greater importance as the incidence of reactors diminishes. The Mantoux test is far more accurate and more reliable than the Patch. Hazards of radiation have also given greater importance to this test. Projects should be conducted not only among school children, but also in the preschool child, and among controlled groups of adults. School teachers, school employees, domestics, foodhandlers, relief recipients, college students, municipal workers are some examples of groups where surveys could be regulated.

UNCOOPERATIVE known patients contribute to the annual crop of new cases. This group includes drunkards, derelicts and drifters. They refuse to accept isolation or treatment. Under existing laws they can be quarantined but this is difficult to enforce. They can be committed

to the County Sanitarium to remain hospitalized until no longer a menace. Over 50 have been judged recalcitrant and consigned to the Essex County Sanitarium from Newark alone, in the past five years.

Unknown cases form the paramount source of infection. Regardless of all case finding methods, they are never known or diagnosed until just prior to or after death. They have wandered about during life infecting many contacts. This hazard appears to be increasing since the advent of chemotherapy. The following table displays the proportion of cases reported to the Newark Board of Health just prior to or after death in the last 10 years.

	Per Cent		Per Cent
1950	37	1955	30
1951	21	1956	39
1952	22	1957	29
1953	29	1958	36
1954	22	1959	33

SUMMARY

1. Tuberculosis control requires changing procedures in a community.
2. Mortality statistics in tuberculosis show a steady decline, more marked since the advent of chemotherapy. Morbidity is falling at a much lower rate.
3. Mass x-ray surveys are costly, locate only a small percentage of cases, and when used, should be restricted to "high incidence areas."
4. Tuberculin testing is economical, and the best method for a control program.
5. Recalcitrant patients should be committed to a sanitarium until non-infectious.
6. The unknown case forms the greatest source of infection in tuberculosis.

18 Waverly Avenue

Poisoning by Potatoes

On three consecutive Sundays four people had the same symptoms of food poisoning after eating cold meat with baked potatoes. Another member of the family who ate the flesh but not the skin of the potatoes remained well. On each occasion, abdominal pain, diarrhea and malaise came on about nine hours after the meal. The patients recovered within 24 hours.

Analysis* of potatoes from the same batch showed that they contained 50 milligrams of solanine per 100 Grams. Average solanine in potatoes is about 9 milligrams per 100 Grams. The upper safe limit of solanine is 20 milligrams. The symptoms and incubation period were similar to those described in previous outbreaks of solanine poisoning (Glasgow in 1917, Cyprus in 1932 and Germany in 1928).

The conditions under which an excessive amount of the alkaloid is formed in potatoes are not well defined. The highest content is found in parts of the plant where metabolic activity is greatest—in the sprouts and in or immediately under the skin.

Factors likely to increase the normal solanine content include exposure to light while the tubers are forming or after they have been dug; planting the potatoes near the surface of the soil and not earthing them up during growth; growing in a hot country; and damage to the tops of the growing potatoes by hail or frosts.

Solanine is water-soluble and is diffused by boiling but not by baking. This explains why potatoes of the same batch had been used for some weeks in a hotel without incident, while the baked potatoes eaten in their skins caused illness.*

*Wilson, G. S.: Bulletin of the British Ministry of Health (London, England) 18:207 (December) 1959.

STUART S. STEVENSON, M.D.

Jersey City

Physical Fitness of the School Child*

In this outspoken address, Dr. Stevenson takes a hard look at the traditional athletic program in our schools and pin-points its liabilities. He offers suggestions for constructive solutions.

"Athletic play comes naturally to children as it does to the young of animals. It is a vital function, a testing of wings, a preparation for food-getting, fight or flight, in addition to being in itself one of life's great enjoyments—in other words, 'fun.' The trend in our society is for fewer persons to participate more intensely in athletics, while growing proportions are relegated to the ranks of spectators. Indeed, with the prevalence of the automobile as the major means of locomotion, replacing walking and the bicycle, many adolescents get most of their exercise via the sport page and the television set."[1]

NEED FOR ATHLETICS

A CHILD needs guided athletic activity in school for several reasons. Beginning way back at ages six or seven years, certain hormones are secreted which act to build muscle tissue. Such tissue needs to be exercised or it will not grow and develop properly; indeed, it will atrophy. An extreme example of the results of muscular disuse is the child at complete bed rest, with rheumatic fever for instance, or in a body cast. He loses both muscle and bone substance. Such body wastage is a recognized and serious medical problem.

A child needs guided athletic activity during the school years because his muscles have the potential to grow for only a limited time, during the period of general growth. If these muscles are not properly used during this time, they cannot be developed later. Indeed, the Army found that it might take a middle-aged man and thin him down, put him into "trim," but it could not give him muscles if he had not developed these in his youth.

Athletic activity develops coordination and motor skill in the child and he learns to use his muscles with agility and efficiency. This is important if it only allows him to enjoy life more fully: to play a better game of golf or tennis.

Every child needs the experience of athletic competition to help to train him for the competitive situations which he must face and master in successful living. And athletic activity offers a physical outlet to the frustrations and pressures of modern life. The commonest modern psychoneurosis is probably the "effort syndrome" with its fast pulse and respirations and its incapacitating anxieties. This seems, in many ways, to be the opposite of the trained physical state.

Last, in all candor, a child needs athletic activity in order to make him (or her) more presentable, esthetically, as a human being.

THE NEED IS GENERAL

MOST of us are not destined to become professional athletes. The stated needs for

*Dr. Stevenson is chairman of the pediatric department at Seton Hall College of Medicine. This paper was presented at Seton Hall on April 2, 1960 as part of a colloquium on school athletic injuries. The seminar was sponsored by the Child Health Committee of The Medical Society of New Jersey.

1. Lurie, P. R.: Pediatric Clinics of North America, 7:173 (1960).

school athletics do not imply this. I remember the day that I failed penmanship in grade school and I remember well my father's defense of this failure: he told the teacher that a man who achieved a successful career would have a secretary and would not need to write well. To this day, my penmanship remains atrocious. This lack of writing skill has not been fatal, but life would be easier and more pleasant if my friends could read my letters.

Athletic training, to a minor degree, is comparable. The average child will not become a professional athlete. Nevertheless, with muscles and heart and lungs conditioned and trained, he will likely lead a better adjusted, fuller, happier adult life.

HOW ABOUT CORONARY DISEASE?

"People with well developed muscles die of coronary heart disease." This fallacious statement, frequently quoted, is based on a misleading correlation. It is true that a man with the type of physique which excels at football and heavy sports is a man who is prone to coronary thrombosis. He cannot change his physique but heavy physical work, continued over many years, will actually protect him against such a cardiac catastrophe. The football player leaves college "in the pink." As a business man, subjected to the stresses of sedentary modern living, he loses rapidly his excellent state of physical training—and has his coronary.

In a recent study[2] of London bus drivers and conductors, it was found that the drivers and conductors tend to be the same types of men with the same environmental backgrounds. The only discernible way in which they differ is that the drivers have a sedentary job while the conductors climb up and down the steps of the double decker buses all day long. The sedentary drivers had a significantly higher incidence of coronary heart disease; and had it in a more severe form.

The heart of a normal adult, according to reputable physiologists, cannot be damaged by excessive exercise.

CRITICISMS OF THE TRADITIONAL PROGRAM

There is too much emphasis on intensive training for a select group of talented athletes with victory as the only goal. (A professional boxer told me[3] that he had more training in college for a three round bout than he did later in his career for a fifteen rounder!). This group would probably get its exercise in any event. In the meantime, the rest of the school population, which most needs training, is neglected. This is serious. All of our children need guided physical activity.

Competition is good training for living; but over-competition means inefficient utilization of energy. Well-known is the person who loses sleep in the face of the culmination of an important tournament, who develops chronic fatigue, who goes "stale." Over-competition, in addition, may cause a sense of inferiority to develop in an immature personality. Finally, high school boys have relatively small hearts. The heart is the last muscle in the body to grow and develop to maturity. A fifteen-year old boy may have the physique and body muscles of a college athlete but his smaller heart is limited in its ability to pump blood. This basic physiologic fact means that he fatigues more easily and cannot take the physical stresses with which his college colleague can cope. Yet it is this same physiologic fact which is so frequently disregarded in strongly competitive school athletic programs.

The school athletic program must not be pushed to the detriment of other, and equally important, activities of growing up. "In these days of interplanetary apprehension, homework assignments are most demanding and, if athletics are to keep a broad base, participation and scholarship must not be mutually

2. Morris, J. N., and others: Lancet, 2:1053 (1953).

3. Personal communication to the author.

exclusive. Jobs and social and cultural pursuits have a place, too, in the development of a rounded adult."[1]

The school athletic program needs the guidance of physicians. It is not sufficient that these be just men with M.D. degrees; they should be clinicians, especially pediatricians trained to safeguard the child's health. And such doctors have been conspicuous by their absence in school athletic programs. At the Seventh National Conference on Physicians and Schools, there were 100 official participants. Only 35 of these were doctors of medicine; and most of these 35 were public health administrators. Personally, I recognized in the list only one clinical pediatrician. The blame for this lack of clinical, professional guidance does not lie with those who have stepped into the breach. It lies with the pediatricians who, even though they have not been approached by lay officials, have not exerted themselves and who have not given their proper leadership to this area.

The medical clinician knows that children vary in muscle mass which is under hormonal control. He knows that children vary in their abilities to coordinate which are dependent upon the brain's cerebellar control. He knows that children vary in competitive ability and in the ability to withstand stress. He knows, best of all, that bitterly-competitive athletics penalize the child who does not have the physique of an Apollo and who cannot be reconstructed to possess it. Finally, only the clinician can examine a child and certify that his heart, his lungs, his bones—his *body*—are fit for participation in athletics.

CONCLUSIONS

1. In our cultural pattern, our children do not get the needed exercise in their daily ritual of living.

2. Every child deserves and needs guided physical activity and competition: to allow his (or her) body to grow and develop to as optimal a state as innate endowment will permit; to teach him the rewards and trials of competition; to train him to use his muscle groups with agility and efficiency, to the useful end that he may enjoy his life more fully; to allow him a physical outlet, a safety valve, for the frustrations of modern living; to help make him more presentable, esthetically, as a human being.

There is currently, in our schools, too much emphasis on the intensive training of an elite group of athletes, with victory as the only goal. This bitterly competitive, "crash training" may exhaust the recipient and warp his personality. It often loses sight of the fact that intellectual pursuits have parallel demands on the time and energy of a growing human being if he is to become a mature, happy and useful adult. Very seriously, this intensive training of a small, select group neglects that other group of children which, most of all, needs guided physical activity.

The practicing physician, especially the pediatrician with his unique knowledge of the health, handicaps and diseases of children, is assuming too small a role in the supervision of school athletic programs.

The school athletic program is, properly, a concern of the whole community and is important, and needed, by all of our children.

Seton Hall

Lop Ear Correction

Keeping a cap on an infant or pinning back his ears with adhesive tape does not help to correct ears that stick out prominently from the head, often called lop ears. Dr. Edward A. Kitlowski, Baltimore plastic surgeon, said the earliest desirable time to correct a child's prominent ears by surgery is when the youngster is four or five, to protect him from ridicule by classmates when he enters school.—*American Society of Plastic and Reconstructive Surgery Annual Meeting,* October 14 1958.

Edward E. P. Seidmon, M.D.

Plainfield

Prophylaxis and Treatment of Bee and Wasp Sting Allergy*

An insect sting is no laughing matter. Apart from local discomfort it is a potentially serious syndrome. In this series there was a one per cent mortality rate.

Increased interest is being given to insect stings, especially so because of the severity of repeated episodes of stinging. Evidence is here presented indicating severe reactions and even a fatal outcome in minutes following a bee sting. Hospital emergency room attendants, first aid squads and physicians should be appraised of the possible emergency.

The venom of the arthropods (*Class*: Hexapoda; *Order*: Hymenoptera; *Species*: Wasp, Yellow Jacket, Hornet, Honeybee and Bumblebee) when injected into man, results in systemic symptoms manifested by allergic sensitization to the substances in the venom.

Allergic manifestations of these insect stings vary from local intense burning, induration, edema, rapid pulse, suffocation, cough; to more advanced symptoms of vasomotor rhinitis, generalized body edema, dyspnea, bronchial asthma, marked sensation of choking and constriction of the throat, malaise; to marked reactions of blurring of vision, severe angio-edema, cyanosis, vascular collapse, involuntary sphincter and bladder control, hemorrhagic frothing of the mouth, loss of memory, stupor, semiconsciousness and unconsciousness. The symptoms appear to become more intense with each episode of stinging. When death occurs, autopsy findings include general visceral congestion with petechial hemorrhages, acute gastro-enteritis, myocarditis and edema of the larynx.[2] Schenken *et al.*[3] say that the important autopsy findings in bee sting allergy are pulmonary emphysema and edema; cerebral edema and intraventricular hemorrhage; dilatation of the heart; fatty metamorphosis of the liver; visceral congestion; congestion of the nasal sinuses. The occasional death due to insect sting is probably an anaphylactic reaction with earlier sensitization to insect venom.[4]

As for the chemistry of wasp venom, Schachter[5] states that there are three substances present: histamine, hydroxytryptamine and a polypeptide called *kinin*. Kinin produces contraction of the isolated guinea pig ileum and a fall in blood pressure in the cat and rabbit, and also increased capillary permeability.

Loveless and Fackler[7] have indicated by immunologic methods that the five hymenoptera (yellow jacket, bald-faced hornet, paper wasp, honeybee and bumblebee) possess a common allergic specificity. Each also contains in its venom a component specific for the species. The honeybee appears to be more

*This paper was read May 18, 1960 before the Allergy Section of The Medical Society of New Jersey. This work is from the Allergy Unit of the Hunterdon Medical Center in Flemington, N. J.

closely related to the three wasps, and the three wasps have much in common with each other. Foubert and Stier [1] have substantiated Loveless's work [7] with gel diffusion studies. They have shown that yellow jacket, yellow hornet, black hornet, wasp and honeybee contain common antigens; that yellow jacket antigen is the most potent sensitizer of the heterogeneous antigens. The closest relationship to bee antigen appears to be wasp venom.

Braun,[8] in 1925, was one of the first to document hyposensitization therapy to hymenoptera venom. He prepared a saline "brew" of the wild honeybee by snipping off the posterior ⅛ inch of the body which contained the venom sac. This extract was given in gradually increasing doses on scarified skin surfaces. When the patient demonstrated no signs of allergic reactions to this concentrated extract, it was then injected intramuscularly into the arm. By 1944, Brown [9] and later Mueller [10] demonstrated clinical immunity against hymenoptera venom in a limited number of subjects by the injection of graduated amounts of whole body extract. It was shown by Benson,[11] Rockwell,[13] and Ellis [14] that the sensitizing antigens were contained in the entire body of the insect; that the sac venom and the extract of the insect body gave equal results with diagnostic skin testing and on hyposensitization therapy.

In this study 95 cases of stinging by the paper wasp, yellow jacket, hornet, honeybee and bumblee were observed in a 6-year period at the Hunterdon Medical Center, in rural Hunterdon County, New Jersey.

Of the 95 patients, 29 were females. The age grouping was:

Age Bracket	Patients
1-10	23
11-20	15
21-50	40
51-60	13
61-70	4
	95

The yellow jacket accounted for 65 of the 95 stings. The paper wasp was responsible for 26. Bumblebee, hornet and honeybee accounted for 2, 4 and 6 respectively.

All of these 95 patients required either emergency medical care or more heroic care in the hospital for several days or longer. In all, 88 patients ranging in ages from 1 to 70 years, were given immediate emergency treatment in the hospital and released to their homes. Seven were sick enough to require in-patient hospital therapy, treatment for shock and other emergency medical care.

There was one death. A farmer, 64 years old, had a history of being stung by a yellow jacket for the first time twenty years ago. Each year thereafter he was stung again and suffered burning, itching, and marked swelling at the involved area. With each stinging, his symptoms became progressively worse. In 1958 he was stung by a yellow jacket and brought to the emergency room of the Hunterdon Medical Center. He had profuse perspiration, chills, syncope, cyanosis, protrusion of the tongue and incontinence of feces and urine. He was hospitalized and given epinephrine, supportive therapy, steroid drugs and treatment for shock. On discharge he was instructed to report to the Diagnostic Center for bee venom hyposensitization therapy. He failed to do so. In September 1959, steeped in sweat while working on a farm tractor near his home, he received a sting on the left ear from a yellow jacket. In great haste he drove up to the house, calling to his wife to summon the doctor. But, before she could get to the phone he collapsed in an anaphylactic death.

TREATMENT

TWENTY-TWO patients received hyposensitization treatment with yellow jacket and wasp extract. One patient complained of blurring of vision with the first 0.1 cubic centimeter of a one-to-a-million dilution of whole body bee-and-wasp extract. However, there was no further reaction on subsequent hyposensitization therapy. Another patient developed urticaria with 0.2 cubic centimeter of a one-to-ten-million dilution of extract. The extract was then diluted to one-to-100 million and 0.1 cubic centimeter was given on the

starting dose. No further reactions were encountered and the patient is now receiving treatment with 1 to 1000 dilution.

Intradermal skin tests were done on patients in dilutions of one-to-a-million and graduated upward to 1 to 100. At the point of a 4 plus reaction no further testing was done. If the patient had a history of a severe constitutional reaction to a sting and if the intradermal test was 4 plus at a dilution of 1 to 10,000, the treatment was arbitrarily started at 1 to 100,000,000. At no time was the starting hyposensitization dose less than one to a hundred million: the strongest maintenance dilution was one-to-a-hundred.

DOSAGE SCHEDULE

Dilution 1 to	*Given Every*	*Dosages (tenth of a c.c.)*
100 million	3 days	0.1-0.2-0.4-0.6-0.8-0.9
10 million	3 days	same
1 million	3 days	same
100,000	3 days	same
10,000	7 days	same
1,000	7 days	same
100	28 days	0.5 c.c.

The treatment is advised to be given for a minimum of three years. This method of treatment is in accord with that of Mueller.[15]

RESULTS

REPEAT insect venom sting in one patient (stung 3 months after treatment was started) developed urticaria only. Another who was stung 2 months after treatment had begun, developed profuse sweating and angioedema. He was stung by a hornet and wasp, one year after treatment was started, and had no demonstrable swelling and no symptoms. One patient stung by 2 yellow jackets, six months after treatment was initiated, had no swelling or reaction. This patient was stung again by a wasp, one year after treatment was given, and had a slight swelling at the site of the sting.

Yellow jacket bees, paper wasps, hornets, bumblebees and honeybees gravitate to people wearing scented perfumes. The odor of body sweat, bright objects of metal or jewelry and worsted or flannel clothing of black, brown or red color apparently attract stinging bees. The movement of a person as in an upright or walking position, or the swatting at bees increases the chances of being attacked and stung.

IMMEDIATE CARE

THE honeybee has a barb which, stinger and sac, is deposited into the skin. The stinger should be removed by immediately scraping off with a sharp object or the nail. The sac remaining on the stinger continues to pulsate and inject venom into the tissues. *Do not grab the sac or stinger either by the use of finger nails or forceps.* This simply forces the remaining venom into the skin.

The medical emergency treatment for insect venom stings includes injectable antihistamine drugs as Benadryl® or Chlor-trimeton® maleate, epinephrine hydrochloride, isoproterenol hydrochloride, steroid drugs, oral stimulants and external heat. In the more seriously ill patients, intravenous ACTH in 500 cubic centimeters of saline solution is given. Ten units are administered every two hours to a total of 80 units. In severe bronchial asthma with syncope, an oxygen tent is advisable. Patients with a history of a previous allergic constitutional reaction from an insect sting are instructed to carry a hypodermic syringe and needle, an ampoule of epinephrine hydrochloride (1 to 1000) and an antihistamine drug.

COMPLICATIONS

THE paper wasp builds its nest in radiating open chambers under the eaves of a house and uses chewed wood pulp mixed with ground water in the cementing process. His stinger is usually contaminated with pyogenic organisms. Likewise, the hornet's nest is made of mud and the yellow jacket burrows into the ground. The sting of these three insects

is frequently contaminated and it is not unusual to have a secondary streptococcal or staphylococcal infection following the sting.

Honeybee keepers frequently state that early in their careers the sting of a honeybee causes mild symptoms, but later, following repeated stinging they are not affected by the sting. This signifies the gradual hyposensitization to the honeybee. Honeybee keepers frequently complain of vasomotor rhinitis and asthma when they are about bee hives. This is due to the scaling and emanations of the insect itself.

SUMMARY

1. Ninety-five patients have been treated for poison venom stings of the honeybee, bumblebee, paper wasp, hornet and yellow jacket.

2. Twenty-two patients received hyposensitization therapy with yellow jacket and wasp extract.

3. Four of these patients were stung after receiving treatment and had only local swellings.

4. One patient who had no treatment died in 25 minutes after being stung by a yellow jacket bee.

5. Yellow jacket stings appear to cause the most severe symptoms.

6. Death may ensue from repeated insect venom stinging of the order: *Hymenoptera.*

7. While working in the garden or in the fields, during the warm months when these poisonous insects thrive, perfumes should be avoided. Also, those exposed in gardens or fields should not wear clothing of black, brown or red colored flannel.

221 West Seventh Street

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Too Much Milk?

Animal studies suggest that disturbances occur when calcium intake exceeds 1 Gram a day in human beings (one quart of milk contains 1 Gram of calcium) or 1 per cent of the diet in animals, reported G. K. Davis of the University of Florida at the annual meeting of the Society for Experimental Biology. High calcium intake is associated with disturbances involving the kidney. Some forms of anemia and goiter may be caused by too much calcium and too little other important nutrients. The recommended daily requirement of calcium in the United States is 0.8 Gram.—*Medical Science,* May 10, 1959.

Michael LaPorta, M.D.

West Long Branch

Carol Fuhse, CRNA

Neptune

Halothane* in Pediatric Anesthesia

In less than two years, halothane has gained a unique place in pediatric anesthesia because of the numerous advantages here spelled out by Dr LaPorta and Miss Fuhse.

Halothane (Fluothane®) is a halogenate—specifically, trifluoro bromchlorethane. Introduced in England by Raventos [1] in 1956, it has been widely used in this country since 1958. It appears to be twice as potent as chloroform and four times as potent as diethyl ether.[2] Halothane* is no more toxic than diethyl ether but it has a narrower margin of safety.

Since it is noninflammable and nonexplosive, halothane* allows for a variety of applications in today's operating rooms which are crowded with electric and electronic instruments.

One of the remarkable properties of this agent in pediatric anesthesia is its ability to provide a smooth, quiet, and fairly rapid induction. A distinct aid in this regard is its pleasant odor, "like Mommie's nailpolish," in low concentrations, which facilitates the handling of a child. Pharyngeal and laryngeal reflexes are obtunded early and markedly—more so than with most other agents at light levels of anesthesia, and an airway can be inserted sooner into the child's retropharynx. Fluothane® is nonirritating to the upper respiratory tract, even in the occasional emergency operation where the child has had a "runny" nose or bouts of cough. It does not influence salivation even in those few instances when pre-operative medication has not been administered. When an intravenous infusion is needed the veins are easy to find even in the chubbiest lad. When an endotracheal tube is indicated halothane* provides good muscular relaxation after only three or four minutes of induction. Induction with Fluothane® allows for a shift to open drop ether without the possibility of laryngeal spasm so often encountered when the shift from cyclopropane to ether is made.

The respiratory rate is rapid at first, then becomes shallow and slow and finally stops when a deep plane of anesthesia is established. Pulse rate becomes slower until a marked bradycardia occurs, concomitant with the increased blood level of the halothane.* The child's cardiac rhythm is dominated by the sympathetic system, hence the bradycardiac effect of halothane* provides a good balance, although the pulse rate should not be allowed to slow below 60 or 70 per minute. Fluothane® provides good muscular relaxation but we prefer using succinyl choline (as Anectine®) to achieve this without the necessity of increas-

1. Raventos, J.: British Journal of Pharmacol., 11:394 (Dec. 1956).
2. Artusio, J. F.: Chapter 13 in *Drugs of Choice* (edited by Walter Model) St. Louis, 1960. Mosby, page 247.

*We used the brand tradenamed as Fluothane® by Ayerst Laboratories.

ing the concentration of the anesthetic agent to the limit of its safety.

Analysis of the subjoined table shows the versatility of halothane.* The age of patients ranged from 2 weeks to 13 years and the premedication was the same as that used with other agents. The induction technic involved a mask attached to a non-rebreathing Fink valve, a Stephen-Slater mask, or an open drop mask. When the child weighed 50 pounds or more, the regular semi-closed circuit was usually employed. In every instance careful control of the vapor volume flow was maintained.

We have been using the Fluotec Mark II, but a copper kettle or other special vaporizers can be employed. It is essential that a low concentration of halothane* be delivered; therefore we usually start with 1 or 1.5 volumes per cent with a high flow of 50-50 nitrous oxide and oxygen. As soon as the pulse rate slows, we decrease the concentration of halothane* and usually our patients can be maintained between 0.3 and 0.8 per cent vapor volume. When we anesthetize infants we secure them to the operating table but often allow them to move until we have ascertained the amount required to keep them under very light anesthesia, yet simultaneously providing a quiet operating field. If the vapor concentration is kept in this range and carbon dioxide is not allowed to accumulate no marked change of cardiac rhythm is noticed.

The 200 children who received halothane* underwent surgery for:

35	closed reductions of extremities
30	tonsillectomies-adenoidectomies
20	cardiac catheterizations
20	inguinal herniorrhaphies
15	operations for strabismus
10	operations for Tetralogy of Fallot
10	umbilical herniorrhaphies
10	appendectomies
8	inter-atrial defects
5	inter-ventricular defects
5	cystoscopies
5	circumcisions
5	suturing of lacerations
4	craniotomies
3	lachrymal duct probes
3	pulmonic stenosis
3	patent ductus arteriosus
2	spinal fusions
1	nephrectomy
1	splenectomy
1	coarctation of the aorta

We have had experience with thirty cases involving cardiac surgery and twenty cases of cardiac catheterization which were all monitored with continuous electrocardiography, intra-arterial pressures and venous pressures by means of a transducer. We can now honestly say that the more we learned of this agent, the fewer were the incidences of hypotension or arrhythmias. The twenty cardiac catheterization patients were anesthetized by the open-drop technic in "the darkness of the fluoroscopic room." We often allowed the vapor volume to rise so that the respiratory rate became slow. We then noticed changes in the electrocardiograms that disappeared promptly when the respirations were assisted by the Ambu apparatus delivering air. Hence, we have arrived at this postulate: do not allow carbon dioxide to accumulate any higher than normal. This can be achieved only by assisting the patient's respirations when the least depression appears.

Ten of the twenty open heart operations were performed on children with cyanotic Tetralogy of Fallot. They all tolerated the anesthetic well. The cyanosis almost disappeared during anesthesia due to a very high concentration of oxygen in the mixture delivered. In all of the fifty children where some procedure on the heart was performed the anesthetic course was uneventful even if, in some of them, hypothermia as low as 45 degrees was induced. Only one child with the Tetralogy of Fallot was lost on the operating table. This occurred at the end of the operation and with no evidence of any relationship to the anesthetic used.

Halothane* is excellent in tonsillectomies and adenoidectomies. But an endotracheal tube is necessary, so that some surgeons object to the technic. Such children undergoing tonsillectomies can be kept under very light anesthesia and they are fully awake by the time they reach the recovery room. No nausea and

vomiting was noticed and children take fluids and move around without that usual wornout appearance so common with ether.

A clear demonstration of the superiority of this agent was seen in a four-year old girl born with multiple congenital defects and requiring a series of operations, at present her seventh. Most troublesome for the anesthetist was a macroglossia and a continuous sialorrhea. She was operated upon in a New York hospital. An emergency tracheotomy was done postoperatively, probably due to excessive secretions obstructing the respiratory tract. The fourth and fifth operations were at the Fitkin Memorial Hospital where a previous attempt to anesthetize her met with postponement of the procedure because of respiratory embarrassment. Following the fifth operation, she developed pneumonia. During the past two operations Fluothane® was used and even though it took 2½ hours to complete each procedure the operative and postoperative courses were uneventful. Even her parents noticed the difference.

A two-year old girl underwent a two-stage spinal fusion and was easily carried on 0.3 per cent Fluothane® with 50-50 nitrous oxide and oxygen.

An eight week-old, seven pound infant underwent a thoracotomy and decortication for residual staphylococcic pneumonia. This tiny baby was continuously secreting and draining thick secretions from the affected to the normal lung but, carried on halothane* with a Digby-Leigh valve, two-hour surgery was done uneventfully. The infant was discharged three weeks later.

A one-year old girl had a craniotomy for a compressed fracture of the skull. Halothane* was the main agent and a successful operative and postoperative course was achieved. Three other craniotomies were done in children with head injuries and all had uneventful recoveries.

Lately we have been using Fluothane® for all children requiring very short operations, such as lacerations, mucoceles, and reductions of fractures. Premedication consists only of atropine. The children are discharged from the recovery room one hour postoperatively. We thus help to avoid overcrowding our pediatric ward.

When minor surgery on the head and neck is contemplated, we induce the children with halothane.* Once saturation is reached, we remove the mask and carry the patient with a nasal double hook that delivers a high concentration of halothane.*

SUMMARY

Two hundred children were anesthetized with halothane (Fluothane®) as the principal agent. The superiority of this agent was reflected by its versatility and by the excellent operative and postoperative results. The only significant liability of halothane* is its narrow safety margin. It is, therefore, essential to maintain accurate delivery of known quantities of vapor. The advantages of halothane (Fluothane®) include: (1) absence of salivary and bronchial secretions; (2) lessened nausea and vomiting; (3) no irritation of trachea or larynx; (4) the sympathetic nervous system depression is readily reversible; (5) rapid induction; (6) high potency; (7) rapid recovery; and (8) nonexplosibility.

501 Cedar Avenue

Painting During Pregnancy

Expectant mothers may wield a paint brush without fear of abortion. "There is no basis for the belief that the paint available today will cause an abortion."—J.A.M.A., June 21, 1958.

Bernard H. Chaiken, M.D.

Short Hills

Andrew J. V. Klein, M.D.

East Orange

Gastric Retention and Intestinal Malabsorption in Diabetes Mellitus*

Diabetic neuropathy may involve the autonomic nervous system and produce severe intestinal malabsorption. An interesting case is here presented with a concise review of the literature.

Gastric retention in diabetics (*gastroparesis diabeticorum*) is due to diabetic neuropathy of the autonomic nerve fibers to the stomach, such as the vagus.[1] This results in abnormal gastric retention despite a patulous pylorus as seen after surgical vagotomy.[2] These patients may show other peripheral signs of diabetic neuropathy such as paresthesias, muscle cramps, hypesthesia and hyporeflexia. Nocturnal and diurnal diarrhea, constipation, steatorrhea, malnutrition, impotence, and disordered motor patterns in serial small-bowel radiographs[3] may be due to involvement of the autonomic nervous system.[4] The gastric retention has an insidious onset and is often masked and free of the usually expected nausea, vomiting and abdominal pain of pyloric obstruction.

CASE REPORT

A 28-year old man complained of diarrhea for four months with ten loose fatty stools daily. The stools were without blood or pus; and they floated. He had low abdominal cramping pains, and excessive flatulence.

Three years ago, he first noticed severe thirst and frequent urination. A diagnosis of diabetes mellitus was established. Attempts at dietary and insulin control were not very successful. With the onset of diarrhea, he lost 35 pounds and had increasing weakness, leg cramps, impotence, and tingling of the extremities.

He was an emaciated, chronically ill man without cheilitis or glossitis. Blood pressure was 110/70. Heart and lungs were not remarkable. The abdomen was slightly distended, without masses and with hyperactive peristalsis. Testes were of normal size and genitalia well developed. There was complete absence of patellar and ankle reflexes. His Achilles tendon was hypalgesic on compression, and he had hypesthesia. Vibratory sensation was absent in the legs.

Laboratory studies revealed 6,000 white blood cells per centimeter, with a normal differential count. Hemoglobin was 14.9 Grams, hematocrit 46 volumes per cent, mean corpuscular hemoglobin 30. Color index was .97, mean corpuscular volume 83, mean corpuscular hemoglobin concentration 35. The urine was negative for cells, casts or albumin, but frequently showed 3 to 4 plus glycosuria. Fasting blood sugar was 131 milligrams per cent, blood urea nitrogen 17 milligrams per cent, serum protein 5.7 Grams per cent (albumin 4.2, globulin 1.5), calcium 10.3 milligrams per cent, inorganic phosphorus 4.8 milligrams per cent, and serum potassium 4.2 milliequivalents.

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*From the Gastrointestinal Section, Orange Memorial Hospital, Orange, New Jersey.

1. Kassander, P.: Annals of Internal Medicine, 48:797 (1958).
2. Moore, F. D., *et al.*: New England J. Med., 234:241 (1946).
3. Berge, K. G., *et al.*: Diabetes, 5:25 (1956).
4. Mailman, Richard H.: Annals of Int. Med., 49:190 (1958).

Stool examinations were negative for ova, parasites and blood. A quantitative stool fat revealed 30 per cent of dry weight of stool to be fat. A Schilling test of Vitamin B_{12} absorption was normal. (Vitamin B_{12} labeled with radioactive Cobalt 60 was administered orally. The 24-hour urinary excretion was determined after an intramuscular "flushing dose" of Vitamin B_{12} had been administered. A normal urinary excretion of Vitamin B_{12}-Cobalt 60 demonstrated that normal intestinal absorption had occurred).† Trioleic acid tagged with Iodine,[131] taken orally, revealed poor absorption, with only 4 per cent of the administered dose appearing in the blood within 6 hours.† Oleic acid, tagged with Iodine [131] was also poorly absorbed into the blood, with only 2 per cent appearing within 6 hours. Xylose absorption was impaired with only 2.0 Grams excreted into the urine 5 hours after an oral dose of 25 Grams was given. (In the presence of gastric retention some of the poor absorption demonstrated in the three previous studies, may have been due to retention of some of the administered substances in the stomach. However, a higher proportion of the trioleic and oleic acids left the stomach and should have been absorbed, if absorption had not been impaired.) Cerebrospinal fluid protein was 68 milligrams per cent, with absence of cells. Liver function studies were normal.

Gastric analysis showed 40 units of free hydrochloric acid, with considerable retained food material, and a total gastric residual volume of 300 cubic centimeters.

Gastroscopy disclosed a patulous pylorus. The mucosa was normal, as confirmed by gastric biopsy. Sigmoidoscopy to 25 centimeters, revealed no abnormalities. Basal metabolic rate was plus 6 per cent.

Gastrointestinal radiographs showed a large stomach with about 60 per cent retention of barium after six hours. The pylorus was open and the small intestine filled readily. The pattern was disordered with puddling, segmentation, and dilatation of loops. Barium reached the caecum in one hour.

Course: The diabetes mellitus was controlled with divided doses of regular insulin before meals to a total of 35 units, with a 3,000 calorie diet. Anticholinergic medication and two trials of gluten-free diet (each for one-month periods) were unsuccessful in relieving diarrhea. Methylprednisolone in daily doses of 20 milligrams reduced diarrhea to 4 daily stools, and eliminated nocturnal diarrhea entirely. His mental attitude brightened and his strength improved. He had gained 10 pounds one month later.

The excessive stool-fat content, impaired xylose, trioleic and oleic acid absorption, confirmed a serious malabsorption state. Excellent Vitamin B_{12}-Cobalt [60] absorption, absence of macrocytic anemia, and lack of response to a gluten-free diet, tend to rule out non-tropical sprue. In addition, the patient manifested none of the other signs of sprue such as cheilosis, glossitis, osteomalacia and hypocalcemia. The trioleic and oleic acids labeled with Iodine [131] were both poorly absorbed, and ruled out pancreatic insufficiency as the cause for the steatorrhea. In pancreatogenous steatorrhea, there should be no impairment of oleic acid absorption. In our patient, the significant diabetic neuropathy, the elevated cerebrospinal fluid protein, and the striking gastric retention, suggested that autonomic diabetic neuropathy caused the steatorrhea.

Kassander [1] studied 27 routinely admitted diabetics and found six who presented abnormal gastric retention. These were in moderate to severe diabetics according to Joslin's criteria,[5] and all had had the disease from only 3 to 12 years. The gastric retention was asymptomatic, and was seen in incidental radiographs. Two of these patients were impotent without loss of libido; two had peripheral neuropathy, and occasional to frequent diarrhea, but not steatorrhea. The high incidence (22 per cent) in this series of 27 diabetics suggests that the condition is more common than generally appreciated.

Gastric retention in diabetics was first mentioned by Boas [6] in 1925 and later by Kussmaul and Bouchard.[7] Rundles [8] emphasized the involvement of the autonomic nervous system in diabetic neuropathy. He later reported [9] that of 35 diabetics manifesting neuropathy, five showed significant delay in gastric emptying, and disorders of small bowel motility. Those showing delayed transit or constipation had the same roentgen findings as those manifesting diarrhea.

Marble [10] was one of the first to suggest a

†We are grateful to The Radiology Department at the Orange Hospital Center for the swift and accurate performance of the Schilling test and we are indebted to the Pathology Department at St. Barnabas Hospital for the trioleic acid test.

5. Joslin, E. P., *et al.*: Diabetes Mellitus, 9th Ed. Philadelphia, 1952. Lea and Febiger, p. 97.

6. Boas, T.: Disease of the Stomach. Leipzig, 1925. Georg Thieme. p. 200 of the Ninth Edition.

7. Katch, G., in von Bergman, G. and Stieheten, R.: Handbook of Internal Medicine, Berlin, 1926. Julius Springer, pp. 522-527 of the Second Edition.

8. Rundles, R. W.: Medicine, 24:111 (1945).

9. Hodges, F. J., Rundles, R. W. and Hanelin, J.: Radiology, 49:658 (1947).

10. Marble, A., in Joslin, E. P.: Diabetes Mellitus, Philadelphia, 1952. Lea and Febiger. pp. 480-481 and 485 of the Ninth Edition.

neuropathic origin for the syndrome of diabetic diarrhea, nocturnal or diurnal. In a clinical study of 150 cases of diabetic neuropathy reviewed by Martin,[11] nine out of 14 cases with diabetic diarrhea were shown to also have gastric retention. None of Kassander's patients[1] with gastric retention and diarrhea, manifested steatorrhea, although the published films showed several patients with disordered small bowel pattern. Berge[3] described six patients in whom steatorrhea was associated with diabetes and neuropathy, and two more in whom there was no other clinical evidence of neuropathy. There is no mention of the finding of gastric retention in his cases. Mailman[4] reported another diabetic with steatorrhea, but without gastric retention, who manifested peripheral neuropathy. The steatorrhea in this case responded to prednisone.

Diabetic control is often difficult because of the uncertainties of nutrient absorption. Six small meal findings with crystalline insulin, is the most effective means of supporting these patients. Fractionated gastric aspiration with lavage may be indicated to prevent solidification of the retained food in the stomach. Since this is basically a disorder of gastric propulsion, gastroenterostomy is considered ineffectual. Also there is a hazard of aggravating the malabsorption state after such gastric surgery.[12] Urecholine® and Mecholyl® were ineffectual in stimulating gastric emptying[1] and may aggravate diarrhea.

A more direct approach in treating diabetic neuropathy is not available. Massive doses of Vitamin B complex and Vitamin B_{12} were to no avail.[1] Zinc, found in protamine zinc insulin has been suggested as possibly toxic in diabetic neuropathy.[1] If so, chelating agents may mobilize zinc with beneficial results, as reported in porphyria.[13] At this writing, we are unable completely to assess the improvement in steatorrhea that is occurring in our patient with the use of methylprednisolone. Although there has been no neurologic improvement, adrenocortical steroids appear to have a nonspecific effect on fat absorption, and deserve a further trial in such cases, although their use may warrant increase in insulin dosage.

SUMMARY

A CASE of diabetes mellitus displaying delayed gastric emptying, diarrhea with steatorrhea, and severe malnutrition due to intestinal malabsorption, is presented. These conditions, as suggested by a review of the literature, may be due to diabetic neuropathy involving the autonomic nervous system, in diabetics who may also manifest peripheral neuropathy. In the brittle, hard-to control diabetics, gastro-intestinal study may reveal these complications to be more common than is generally appreciated.

11. Martin, M. M.: Brain, 76:594 (1953).
12. Ruffin, J. M.: Gastroenterology, 34:484 (March, 1958).
13. Peters, H. A., *et al.*: Annals of Int. Med. 47:889 (1957).

148 Great Hills Road, Short Hills
63 Hawthorne Avenue, East Orange

Sterilization Booklet Available

A booklet containing eight authoritative articles on sterilization procedures and controls is being distributed by Becton, Dickinson and Company. It is based on a symposium at Seton Hall University College of Medicine and Dentistry. Topics will include sterilizing surgical equipment, heat, gaseous and chemical sterilization methods, the control of cross infection, skin antisepsis, new horizons in sterilization and the control of sterilization procedures.

For a copy of this 120-page booklet, the physician may write to Becton, Dickinson, Rutherford, N. J.

Seton Hall officials point out that this material is especially important today because the trend toward sterile, disposable medical equipment has transferred more responsibility for sterilization from the user to the producer. Thus it becomes essential for physicians to be familiar with the latest technics in order to evaluate the methods applied by manufacturers.

Proposed Amendment to the Constitution

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1960 Annual Meeting and will be presented for adoption at the meeting in May 1961. It is herewith published in compliance with the Constitutional provision to that effect.

ARTICLE VI — BOARD OF TRUSTEES

(Second Paragraph)

Current	Proposed
From and after May 21, 1953, any member may be elected a Trustee for a maximum of three (3) full terms, provided, however, that if the first two (2) elected terms are successive, there shall be a lapse of one (1) year between expiration of the second and commencement of the third term. The term of any Trustee commencing prior to May 21, 1953, shall not be included in the limitation of three (3) elected terms.	Any member may be elected a Trustees for a maximum of three (3) full terms.

Board of Trustees: October 16, 1960

Among the actions taken by the Trustees at their October 16 session were:

REPORT OF PRESIDENT

The Medical-Hospital Liaison Committee requests approval of the following actions taken at its October 1960 meeting:

In the interest of encouraging the establishment and efficient operation of Tissue, Audit, and Admissions and Discharges Committees in all hospitals, it is recommended that that portion of Dr. McCall's statement to the Commission investigating the Blue Cross Plan which dealt with such committees be sent to the Medical Director of every hospital, with a covering letter urging that such committees be maintained at optimum functional level.

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and carried—the recommendation was approved.

As a means of reducing the cost of drugs to patients in hospitals by having them ordered under generic rather than trade names, it is recommended that The Medical Society of New Jersey endorse in principle the proposal that hospitals establish a formulary system.

Although the Board considered the principle of the recommendation desirable, some members were concerned lest its adoption would result in situations which would preclude physicians from obtaining specified drugs when necessary.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried—that the recommendation be amended by the addition of the following:

"Provided that the details of the system be worked out on a basis satisfactory to the members of each individual hospital staff."

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and carried—the amended recommendation was approved.

The committee discussed the devastating effect upon New Jersey hospitals of the ruling of the Joint Commission on the Accreditation of Hospitals that after December 31, 1960, any hospital retaining interns or residents who are graduates of foreign medical schools and who have not passed the ECFMG examination will lose its accreditation.

Members of the committee unanimously agreed to recommend that both parent state organizations take proper steps through their respective national organizations to induce the Joint Commission to modify or to postpone the effective date of its ruling, in the interest of the care of patients in the hospitals of New Jersey.

Upon motion by Dr. Greifinger—seconded by Dr. Bedrick, and carried—the recommendation was approved; Dr. Allman and Dr. Hughes opposed.

In connection with the position of the New Jersey Board of Nursing prohibiting the administration of blood transfusions by qualified professional nurses acting at the specific direction of licensed physicians, the committee recommended that each association send a vigorous note to the Attorney General deploring the decision of the Nursing Board, and the disservice to patients which it entails; urging him to promulgate an opinion that will make it clear that such nurses so acting are authorized and protected by the provisions of the Medical Practice Act.

Upon motion by Dr. Kaufman—seconded by Dr. Allman, and carried—the recommendation was approved.

STUDENT LOAN FUND

Dr. Jehl reported the Passaic County Medical Society had established a memorial fund in memory of the late Joseph E. Mott, M.D. The goal is $5,000, and as soon as any sizeable sum is received it will be sent to the State Student Loan Fund.

NEW JERSEY WELFARE COUNCIL

Dr. Kaufman, as the Society's official representative to the Welfare Council, attended a meeting on October 6, held to explore the possibility of forming a citizens group to promote the passage of A-699, the public medical care bill. The group seeks public relations assistance in pressing for passage of the bill.

The Board noted that in the normal course of events the bill would be studied by the Council on Legislation, and action recommended. It was further noted that on December 20, 1959, the Board took the following action:

". . . without prejudice as to its stand on implementing legislation, . . . the Board of Trustees approves in principle the recommendations of the New Jersey Commission to study the Administration of Public Medical Care."

Upon motion of Dr. Kaufman—seconded by Dr. Allman, and carried—the Board reaffirmed its position of December 20, 1959.

COUNCIL ON THE CHRONIC SICK

Commissioner Kandle of the State Department of Health has requested the Society to submit nominations to the Governor for appointment on the State Advisory Council. The term of appointment is two years, limit two terms, and the incumbents, Dr. Pessel of Trenton, and Dr. Hahn of Newark, have both served two terms.

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and carried—the Board approved submission of the following nominations, in the order of preference, to Governor Meyner for appointment:

For Dr. Pessel's place—David Eckstein, M.D., Trenton or Thomas C. DeCecio, M.D., Cliffside Park

For Dr. Hahn's place—William D. Kimler, M.D., Haddon Heights or Laura E. Morrow, M.D., Passaic

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and carried the report of the President was approved as modified.

CANCER SOCIETY REFERENCE LIST

A letter was read from the New Jersey Division of the American Cancer Society asking consideration for "a request from the New Jersey Association of Osteopathic Physicians and Surgeons to have the names of their members included in the *List of Physicians* willing to conduct health maintenance examinations in their private practice . . ." It was noted that the Medical-Surgical Plan of New Jersey list of "Participating Physicians" includes the names of osteopaths fully licensed in New Jersey.

Upon motion by Dr. Buchanan—seconded by Dr. Jehl, and carried—the Board voted concurrence in the recommendation of the Judicial Council that compilation and publication by the Cancer Society of a list of examining physicians be divided into two sections: (1) Doctors of Medicine and (2) Doctors of Osteopathy.

CHIROPODY

Through oversight, the following item from the July 27, 1960, meeting of the Council on Legislation was not reported to the Board of Trustees:

A letter from the State Department of Health set forth an opinion from the Attorney General of Connecticut concerning the use by chiropodists of certain drugs administered by mouth or by injection. The Council recommended that a request be made to the Attorney General of New Jersey for a declaration concerning the use by chiropodists of certain drugs administered by mouth or by injection.

Upon motion by Dr. Greifinger—seconded by Dr. Blaisdell, and carried—the recommendation was approved.

The council considered S-266—a measure which (by supplying a new definition of chiropody) would widely extend the scope of practice of chiropodists in New Jersey.

The council studied the bill and an analysis of it by the Legislative Analyst; gave attention to representations opposing the bill from the New Jersey Orthopedic Society and the Radiologic Society of New Jersey; considered a statement from a lecturer at the Temple School of Podiatry declaring the course given to podiatrists does not prepare them for any type of surgery; and noted a report that the Temple University School of Podiatry had closed in June, 1960, and that none of the five existing schools in the United States has a university affiliation.

After study and discussion, the council approved the following:

(1) Recommend active opposition to S-266 as contrary to the public interest and involving invasion of the practice of medicine by unqualified individuals.

(2) Recommend that the Board of Trustees consult with the State Board of Medical Examiners to discover on what basis the State Board moved to approve the new definition and to ascertain whether the State Board of Medical Examiners, in view of the position of The Medical Society of New Jersey, would reconsider its position with the aim of ultimately reversing that position.

(3) In the event that the State Board of Medical Examiners proves unwilling to or cannot as impractical bring its position into conformity with the position of the Society, the Council on Legislation recommended that the Board approve the council's purpose vigorously through keymen and communications to try to induce the Senate to reject S-266, and to urge a public hearing on the measure, if that becomes necessary.

Those Trustees who are also members of the State Board reported that approval had been given only to the definition of chiropody, as contained in lines 31 through 35 of the bill, which was submitted by the chiropodist member of the State Board. Approval of the definition was by a divided vote. At its October 12 meeting the State Board of Medical Examiners voted to reconsider the action approving the definition.

Dr. Stess, chiropodist member of the State Board of Medical Examiners has assured Dr. Buchanan that no immediate attempt will be made to bring the bill out of the Senate Committee until after a conference is held with representatives of the Medical Society.

Upon motion by Dr. Greifinger—seconded by Dr. Blaisdell, and carried—the Board approved the first two recommendations of the Council on Legislation.

In view of the fact that the State Board will reconsider at its November meeting its approval of the definition of chiropody, the Trustees took no action on the third recommendation.

Dr. Allman moved—seconded by Dr. Buchanan, and carried—that the Council on Legislation, or a committee thereof, together with the Executive Committee of The Medical Society of New Jersey, meet with Dr. Stess and whomever he wishes to accompany him, to discuss S-266 at an early date.

Dr. Jehl moved—seconded by Dr. Lloyd, and carried—that the Secretary of the New Jersey Orthopedic Society and the Vice-President of the Radiologic Society of New Jersey be complimented and thanked for their presentations to the Council on Legislation in opposition to S-266.

HEALTH OFFICER QUALIFICATIONS

The council submitted a report of the Legislative Analyst, and an opinion from the Commissioner of Health, concerning a resolution passed by the 1960 House of Delegates calling for legislation to permit "physicians duly licensed in this state to serve as Health

Officers without further license." Both opinions held that such legislation would be a retrogressive step in public health in New Jersey.

The council recommended:

(1) That the report of the Legislative Analyst, in which the Commissioner of Health concurred, together with that of the Commissioner, be referred back to the House of Delegates.

(2) That the policy decision concerning the introduction of legislation, reaffirmed by the Board at its August 21 meeting, be transmitted to the secretaries of all component societies and hereafter to the chairmen of all reference committees for thir guidance, pointing out that requests for legislation must be carefully processed, if the effectiveness of the Council on Legislation is to be preserved in dealing with legislative matters of medical interest.

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and carried—the Board approved the report and recommendations as submitted.

SCR-27

SCR-27 would request the Department of Institutions and Agencies to make a special study of the effect of the 1960 federal amendments to the Social Security Act. This is a culmination of effort participated in by The Medical Society of New Jersey and the American Medical Association. The council recommended:

That a statement by The Medical Society of New Jersey in support of this legislation be made to members of the Legislature and to Governor Meyner, with copies released to all the daily newspapers of the State.

Upon motion by Dr. Blaisdell—seconded by Dr. Kaufman, and carried—the recommendation was approved.

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and carried—the report of the Council on Legislation was accepted.

JUDICIAL RECORDS

A resolution from the 1960 House of Delegates called for an exploration of the possibility of legislation granting the immunity of "privilege" to all procedures of the Judicial Council and the Judicial Committees of the various component societies. The Executive Officer, Legal Counsel, and the Legislative Analyst conferred about this on September 21.

Prior to the conference, both Legal Counsel and the Legislative Analyst had reported that legislation soliciting confidentiality for these records would be futile, in view of the position taken consistently by the Legislature refusing "privileged communication" to physicians.

The following recommendations were offered:

1. That the Judicial Council make available to all county society judicial committees the following form, which must be signed by complainants as a condition precedent to acceptance of a complaint.

Assurance is hereby given to the Judicial Committee of the ..... County Medical Society, that in the matter of my complaint against ....., no suit is presently pending, nor is any contemplated.

I agree that, in consideration of the privilege granted to me at this time to have my complaint heard by the Judicial Committee of the ..... County Medical Society and if necessary to submit an appeal subsequently to the Judicial Council of The Medical Society of New Jersey or the Judicial Council of the American Medical Association, I hereby waive my right to subpoena at any time from the above-named commmittee or councils any record pertaining to same.

Date..... .....
(signature)

Upon motion by Dr. Jehl—seconded by Dr. Hughes, and carried—the recommendation was approved.

2. That the Judicial Council be asked to request the Judicial Council of the American Medical Association to consider setting a limited time during which an appeal from State findings may be taken.

3. That recommendation should be made to the Judicial Council to direct the attention of all judicial committees to the desirability and necessity of their returning any original exhibits received in conjunction with any complaint made to the judicial committees, such as originals of prescriptions, letters, or bills, and so forth.

4. That chairmen of county judicial committees and county society executive secretaries be summoned to a meeting in Trenton, at which time these matters will be presented in detail.

Upon motion by Dr. Greifinger—seconded

by Dr. Featherston, and carried—recommendations 2, 3, and 4 were approved.

WHITE HOUSE CONFERENCE ON AGING

Received and noted was a letter from Governor Meyner stating he had named the following as delegates to the conference: Drs. C. Byron Blaisdell, Benedict M. Duffy, Roscoe P. Kandle, and Abram L. Van Horn.

It has also been learned that Mrs. Paul E. Rauschenbach has been named by the Governor as a delegate.

AMA ALTERNATE DELEGATES

At the September 18 meeting, the Board authorized Dr. Elton W. Lance to attend the AMA Clinical Session as the official alternate delegate. In accordance with the action of the Board "that two alternate delegates be authorized to attend all AMA annual and clinical meetings held in the east," Dr. Bedrick moved—seconded by Dr. Kaufman, and carried—that the Board authorize the allocation of an appropriation to permit Dr. Joseph P. Donnelly also to function in the capacity of an official alternate delegate at the December 1960 Clinical Session.

1960-61 Special and Liaison Representatives and Committees

1. Aged, New Jersey Joint Council to Improve the Health Care of the

Dr. William H. Hahn, Chairman, Newark
Dr. David Eckstein, Secretary, Trenton
Dr. John F. Kustrup, Trenton
Dr. John B. Fuhrmann, Flemington

Equal representation from:

New Jersey Hospital Association
New Jersey State Dental Society
New Jersey State Nurses' Association
Licensed Nursing Homes of New Jersey, Inc.

2. Aging, New Jersey Advisory Committee to White House Conference on

Dr. F. Clyde Bowers, Mendham (appointed by Governor)

3. American Medical Education Foundation, New Jersey Chairman

Dr. Luke A. Mulligan, Leonia

4. Blind, Board of Managers, State Commission for the

Dr. Charles E. Jaeckle (resigned 7/22/60)

5. Blood Bank Commission of New Jersey

Authorized agent of Medical Society in approved Blood Bank programs

6. Blood Bank Commission of New Jersey, Representatives on

Dr. William T. Read, Jr., Camden
Dr. Kenneth E. Gardner, Bloomfield

7. Blue Cross Rider for Diagnostic Services

Dr. Joseph P. Donnelly, Chairman, Jersey City
Dr. Augustus L. Baker, Jr., Dover
Dr. David Eckstein, Trenton
Dr. George L. Erdman, Summit
Dr. Austin J. Tidaback, Plainfield

8. Blue Cross-Blue Shield Joint Rider

Dr. Jesse McCall, Chairman, Newton
Dr. C. Byron Blaisdell, Asbury Park
Dr. F. Clyde Bowers, Mendham
Mr. Richard I. Nevin, Trenton, *Ex-Officio*
Mr. Robert M. Backes, Trenton, *Ex-Officio*
Equal representation from:
Blue Shield (Medical-Surgical Plan)
Blue Cross (Hospital Service Plan)

9. Advisory Committee to Review MSP and HSP Disputed Claims

Regular Members

District
1. Dr. F. Clyde Bowers, Chairman
2. Dr. John J Bedrick
3. Dr. Gerard R. Gessner
4. Dr. Reuben L. Sharp
5. Dr. Nicholas E. Marchione

Alternate Members

District

1. Dr. Elton W. Lance, Alternate Chairman
2. Dr. Robert A. Cosgrove
3. Dr. John A. Kinczel
4. Dr. John C. Clark
5. Dr. John S. Madara

10. Chronic Sick, State Advisory Council on

(2 to be appointed by Governor from Medical Society nominations—2 year terms)

11. Civil Defense Organization, State

Chairman, Committee on Disaster Medical Services (Dr. Winfield Betts, Medford)

12. Crippled Children Commission, State

Dr. Frederick G. Dilger, Hackensack (1961)

13. Diabetes Detection Drive, 1960

Dr. John J. Torppey, Newark

14. Disaster Control, Joint Committee with Hospital Association

Special Committee on Disaster Medical Services

15. Education, Advisory Council to State Department of (appointed annually by Commissioner)

Dr. C. Byron Blaisdell, Asbury Park

16. Education, Liaison with State Department of

Chairman, Special Committee on Child Health (Dr. Robert E. Jennings, South Orange)

17. Executive Committee (Bylaws, Chapter IV, Section 5(b))

President (Dr. Jesse McCall, Newton)
President-Elect (Dr. Ralph M. L. Buchanan, Phillipsburg)
1st Vice-President (Dr. Louis S. Wegryn, Elizabeth)
2nd Vice-President (Dr. Carl N. Ware, Shiloh)
Chairman, Board of Trustees (Dr. Luke A. Mulligan, Leonia)

18. Fluoridation, Joint Committee on

Dr. Charles H. Calvin, Perth Amboy
Dr. Louis S. Wegryn, Elizabeth
(representatives from State Department of Health and New Jersey State Dental Society)

19. Health, Liaison with State Department of

Dr. Elmer J. Elias, Trenton

20. Health Insurance Conference

Dr. Daniel F. Featherston, Chairman, Asbury Park
Dr. John J. Bedrick, Bayonne
Dr. Royal A. Schaaf, Califon
Dr. Marcus H. Greifinger, Newark
Dr. Ralph M. L. Buchanan, Phillipsburg
Dr. Carl N. Ware, Shiloh
Dr. Louis S. Wegryn, Elizabeth
Mr. Richard I. Nevin, Trenton
8 representatives of Health Insurance Council

21. Historian-Archivist

Dr. Fred B. Rogers, Trenton

22. Hospital Advisory Council to State Department of Institutions and Agencies (appointed by Board of Control)

Dr. Luke A. Mulligan, Leonia (1961)
Dr. C. Byron Blaisdell, Asbury Park (1963)

23. Hospital Service Plan Board of Trustees (per HSP Bylaws)

President (Dr. Jesse McCall, Newton)

24. Hospital Service Plan Liaison Committee

21 county advisory committees to MSP

25. House Maintenance, Staff Policies, and Personnel Relations, Special Committee on

President (Dr. Jesse McCall, Newton)
President-Elect (Dr. Ralph M. L. Buchanan, Phillipsburg)
Chairman, Board of Trustees (Dr. Luke A. Mulligan, Leonia)
Chairman, Committee on Finance and Budget (Dr. David B. Allman, Atlantic City)
Chairman, Former House Committee (Dr. L. Samuel Sica, Trenton)
Secretary (Dr. Marcus H. Greifinger, Newark)
Treasurer (Dr. Daniel F. Featherson, Asbury Park)
Executive Officer, *Ex-Officio* (Mr. Richard I. Nevin, Trenton)
Administrative Secretary, *Ex-Officio* (Mrs. Edith L. Madden, Trenton)

26. Lay Health Organizations and Paramedical Groups, Official Intermediaries with

Members of the Council on Public Health as assigned by the chairman

(assignment of official intermediaries from The Medical Society of New Jersey to lay health organizations and/or paramedical groups does not imply endorsement of the organization/group or its program)

27. Legislative Keymen, National

Dr. C. Byron Blaisdell, Asbury Park
Dr. Levi M. Walker, Atlantic City (Deputy)

28. Medical-Legal Testimony, Special Committee on

Dr. Marcus H. Greifinger, Chairman, Newark
Dr. Joseph P. Donnelly, Jersey City
Dr. Ralph M. L. Buchanan, Phillipsburg
Dr. Louis S. Wegryn, Elizabeth
Dr. Jerome G. Kaufman, Maplewood
Dr. Daniel F. Featherston, Asbury Park, Advisor
Dr. Jesse McCall, Newton, *Ex-Officio*

29. Medical Liaison Committee—Dental, Legal, Hospital, Nursing, and Pharmaceutical

President (Dr. Jesse McCall, Newton)

President-Elect (Dr. Ralph M. L. Buchanan, Phillipsburg)

Immediate Past-President (Dr. F. Clyde Bowers, Mendham)

Executive Officer, *Ex-Officio* (Mr. Richard I. Nevin, Trenton)

(where number of representatives from other organization is larger than number of Medical Society representatives the latter will be increased from the Presidential Officers to equal the former)

30. Medical - Hospital - Nursing Conference (Tri-Partite Conference)

President (Dr. Jesse McCall, Newton)
President-Elect (Dr. Ralph M. L. Buchanan, Phillipsburg)
Immediate Past-President (Dr. F. Clyde Bowers, Mendham)
Executive Officer, *Ex-Officio* (Mr. Richard I. Nevin, Trenton)

31. Medical-Surgical Plan Board of Trustees (per MSP Bylaws)

President (Dr. Jesse McCall, Newton)

32. Medical-Surgical Plan Liaison Committee

6 Officers of The Medical Society of New Jersey
21 county chairmen of Advisory Committees to MSP

33. Medicare Fiscal Agent

Medical Service Administration of New Jersey

34. Medicare Program, Special Committee on

Dr. Carl N. Ware, Chairman, Shiloh
Dr. Nicholas A. Bertha, Wharton
Dr. Joseph R. Jehl, Clifton
Dr. L. Samuel Sica, Trenton

35. Mental Health, State Commission on (Study Commission established by Legislature)

Dr. Richard E. Gordon, Englewood

36. Nutrition Council, New Jersey

Dr. S. William Kalb, Newark

37. Pension Plan

Chairman, Committee on Finance and Budget (Dr. David B. Allman, Atlantic City)
Treasurer (Dr. Daniel F. Featherston, Asbury Park)
Chairman, Special Committee on Staff Policies (Dr. Jesse McCall, Newton)

38. Permanent Committee on Blue Cross and Blue Shield Plans of N. J.

Chairman, Board of Trustees (Dr. Luke A. Mulligan, Leonia)
President (Dr. Jesse McCall, Newton)
Executive Officer, *Ex-Officio* (Mr. Richard I. Nevin, Trenton)
(equal representation from MSP and HSP)

39. Public Health Association, New Jersey

Dr. Louis S. Wegryn, Elizabeth (Delegate)
Mr. Richard I. Nevin, Trenton (Alternate)

40. Retirement Plan for Physicians, Special Committee on

Dr. Jerome G. Kaufman, Chairman, Maplewood
Dr. John J. Bedrick, Bayonne
Dr. Albert F. Moriconi, Trenton
Dr. Morton F. Trippe, Asbury Park
Dr. Nicholas E. Marchione, Vineland
Mr. William Allen Steadman, Consultant, East Orange

41. Safety Council, New Jersey State (per Council Bylaws, Medical Society President member of board)

Mr. Richard I. Nevin, Executive Officer (President's representative)

42. Seton Hall Chapter, Student AMA, Advisory Committee to

Dr. Frank S. Forte, Newark

43. Widows and Orphans of Medical Men of New Jersey, Society for the Relief of

Dr. Joseph R. Jehl, Clifton

44. Workmen's Compensation and State Employees, Special Committee on

Dr. Marcus H. Greifinger, Newark
Dr. Andrew C. Ruoff, III, Pompton Plains
Dr. Carl N. Ware, Shiloh

Influenza Vaccine

The U. S. Public Health Service recommends routine immunization and re-immunization of all diabetics, cardiacs, hypertensives, pregnant women, persons over the age of 65 and sufferers from debilitating diseases. These groups are especially vulnerable. The following information is furnished by the U. S. Public Health Service:

The commercial influenza vaccine is an aqueous, polyvalent, killed-virus preparation, with a prescribed antigenic composition for 1960 as follows:

Type	Strain	CCA Units per cc.
A	PR8	100
A_1	Ann Arbor 1/57	100
A_2	Asian	200
B	Great Lakes 1739/54	100

The total antigenic potency of the vaccine is 500 CCA units per cubic centimeter.

The following pharmaceutical houses are licensed manufacturers of influenza vaccine:

Eli Lilly and Company, Indianapolis
Lederle Laboratories, Pearl River, New York
Merck Sharpe and Dohme, Philadelphia
National Drug Company, Philadelphia
Parke-Davis and Company, Detroit
Charles Pfizer and Company, Brooklyn
Pitman-Moore Company, Indianapolis

Recommended adult dose of polyvalent vaccine for the initial immunization is 1.0 cubic centimeter (500 CCA units) subcutaneously, administered on two occasions separated by two or more months. Preferably the schedule of vaccination should be completed each fall. Thereafter, prior to November 1, persons in the groups specified to receive continuing protection and who have already had the initial immunizing series should receive a booster dose of the vaccine subcutaneosuly—1 cubic centimeter.

Influenza vaccination may be expected to be from 60 to 75 per cent effective in preventing the disease.

Reactions. In adult populations, a low incidence of side reactions may be expected. These are most frequently in the form of transient febrile responses or local tenderness at the injection site. Penicillin sensitivity need not be of concern when injecting influenza vaccine, for current preparations contain none of this antibiotic. Since the vaccine is produced in eggs, the Advisory Committee has advised *against* vaccination for persons who are unable to eat eggs or chicken because of food allergy, or who have had a definite allergic reaction, whether urticarial, asthmatic, or anaphylactic, on previous inoculation of an egg vaccine.

In the past, influenza immunization programs have been intermittent, predominately in response to public concern before and during epidemic periods. Epidemics recur in cycles of unpredictable periodicity. Endemic incidence occurs continually. For these reasons immunization of the specified high-risk groups is recommended to begin now and should be continued annually, regardless of the predicted incidence of influenza for a particular year.

194th Annual Meeting

The Golden Merit Award Ceremony

May 14, 1960

The Golden Merit Award Ceremony was convened at 3:30 p.m., Dr. F. Clyde Bowers, President, presiding.

THE PRESIDENT: Ladies and Gentlemen: As President of The Medical Society of New Jersey, it is my pleasant duty to salute several of our colleagues and tell them how proud we are of their attainments. We greet and pay homage to those among us who have devoted fifty years of their individual lives to the practice of medicine.

As a token of our respect, our esteem and our gratitude for their contributions to the profession of medicine, we take this opportunity to bestow upon each of them our Golden Merit Award. Although it may sound trite, there is no better way of expressing our sentiment than to say: Thank you for a job well done.

We, your brethren in The Medical Society of New Jersey, know full well that this plaque which each of you is to receive, in no way is meant to represent a reward for your many years of devoted service to mankind, your many sacrifices for the betterment of humanity, and your many hours of teaching your medical confreres by word and deed. It is just our way of thanking you.

In these troubled days when our beloved profession is being badgered from all sides, is being beleaguered by government and bullied by labor, is being beset by social planners and bedeviled by self-appointed do-gooders, we would do well to seek the sage advice and council of you who practiced medicine during a period when public opinion provided more favorable climate for the vendor of medical services.

Great changes have been wrought in the social-economic sphere of medicine since 1910 and none can know it so well as those of you who have lived through it. You have given us a great heritage, steeped in a tradition of service that is unmatched by any profession. For this, we thank you. But we are now living in a period of great social upheaval and economic uncertainty. We are being falsely accused and unfairly assailed by those who, without justification or provocation, would prefer to see us dominated by government control.

We ask, for your own sake and as part of your reward, that you be spared for many years to come. We ask, with selfish purpose and for fear of our own existence, that you continue your interest and active participation in your chosen profession and that you share with us the wisdom of your years. God bless you all. (Applause)

I will now turn the microphone over to Dr. John Kustrup, Chairman of our Public Relations Committee.

DR. JOHN F. KUSTRUP: I will first call off the list of recipients of the Golden Merit Award. After calling out this list of recipients, I will then call each member individually. Those who are present will then be accompanied by the president of his county society or the representative of that society. The recipient will walk to the front of the stage for the receipt of the award.

The list of recipients is as follows:

(The awards were then presented by the President)

LIST OF RECIPIENTS

BERGEN COUNTY
- Howard Milton Cooper, Rutherford
- John Henry Diedrich Finke, Hackensack

CAPE MAY COUNTY
- Herschel Pettit, Ocean City

CUMBERLAND COUNTY
- Berta Whaland, Bridgeton

ESSEX COUNTY
- John Joseph Burne, East Orange
- Francesco Nicholas Carbone, Orange
- Charles Dane, South Orange
- Simeon Daron, Newark
- Benjamin Applegate Furman, Newark
- Louis Archibald Hilton, Newark
- Paul Livingston, East Orange
- Walter Edward Lundblad, East Orange
- Isidor L. Rettig, Long Beach, California
- Benjamin Jacob Silverstein, Newark
- David Arthur Stern, Newark

HUDSON COUNTY
- James Lawrence Evans, North Bergen
- George Henry Mueller, Denville
- Jacob Rosenberg, Jersey City
- Herman Emanuel Schorr, Elmhurst, N. Y.
- Hugh MacBeath White, Jersey City

MIDDLESEX COUNTY
- Florentine Milton Hoffman, New Brunswick
- George F. Leonard, Highland Park
- Nicholas Szuch, South River

MORRIS COUNTY
Jennie Dean Beaver, Morristown

PASSAIC COUNTY
Theodore Bender, Paterson
Arey Alonzo Butterfield, Passaic
Walter Michael Winters, Paterson

SOMERSET COUNTY
Runkle Fisher Hegeman, Somerville
Emerson Freeman Hird, Bound Brook
Arthur A. Hochheimer, Bound Brook
Clara C. Renner, Blawenburg

UNION COUNTY
Albert Hirsch, Rahway

Dinner Dance

May 17, 1960

The speakers' section of the banquet convened at 9 p.m. in the Carolina Room, Hotel Chalfonte, Albert Abraham, M.D., Toastmaster.

THE TOASTMASTER: Ladies and Gentlemen, Members of The Medical Society of New Jersey, Members of the Woman's Auxiliary to The Medical Society of New Jersey: I shall not welcome you here. This is not my job. But I am glad you are here, nevertheless.

I have a little speech written for this occasion. Here it is. Friends, Romans and countrymen, lend me your ears. I come to praise Caesar, not to bury him. The good that men do lives after them, so let it be with Caesar and Mrs. Caesar, too. He is my friend, faithful and just to me.

Our welcome will be given by Mrs. George O. Rowohlt, President of the Woman's Auxiliary. (Applause)

MRS. GEORGE O. ROWOHLT: Mr. Toastmaster, President and Mrs. Bowers, Distinguished Guests, Officers and members of the Medical Society and Woman's Auxiliary, Ladies and Gentlemen: It is my privilege this evening to welcome all of you and on this festive occasion thank Dr. and Mrs. F. Clyde Bowers for the wonderful job of representing us as they traveled the State together this past year. It was indeed a pleasure to be greeted by their beaming countenances in so many different places on so many occasions.

Dr. Bowers' yeoman effort, not only for the benefit of the Medical Society but on behalf of the Woman's Auxiliary as well, has earned our undying gratitude. This past year he has become a familiar figure to all of us and his clarion words have rung out not only on local levels but on the national level as well. Boy, he told them!

The Auxiliary has enjoyed a wonderful rapport with the Medical Society through Dr. Bowers, Dr. Fritts and Mr. Nevin. We have grown numerically as well as activity-wise through their sound leadership. We have raised $3315 which represents one hundred per cent participation by every organized county as our donation to the Medical Student Loan Fund. The Auxiliary has taken the new baby to heart. We will do all in our power to help our husbands raise this infant to maturity.

Dr. Bowers, with his sympathetic understanding of Auxiliary matters, helped to further our theme of joining hands for better medical achievement. I know that future officers of the Auxiliary will have as much cooperation from the members of The Medical Society of New Jersey as we have enjoyed in this past year.

Please, everybody, enjoy this wonderful evening of tribute to two marvelous people. (Applause)

TOASTMASTER: Thank you, Mrs. Rowohlt.

Now I would like to take this opportunity to introduce to you Mrs. Ralph K. Bush, President-Elect of the Woman's Auxiliary. (Applause)

And I would like to take this opportunity to introduce to you Jesse McCall, President-Elect of The Medical Society of New Jersey. (Applause)

PRESIDENT-ELECT MCCALL: I have been doing for the last hour a stunt that was taught me sometime ago—trying to think of what I might have to say if I had to get on my feet at some particular time. I thought about it rather selfishly in a way, because I wanted to identify the only one of two counties in the State that does not have a Woman's Auxiliary. I wanted to identify possibly some particular slogan or some campaign that would help me in the coming year as far as The Medical Society of New Jersey is concerned.

I'm smiling and yet I am, I assure you, very,

very serious because as a result of all this mulling over thoughts, messing up dessert after my regular meal, I could think of only one particular thing; that is, a very sincere sense of gratitude for the position I hold and the fact that I have followed a man in office who has laid out a plan of action, a course of conduct, a sense of dedication to duty that, although it would be hard for me to match, is about the most wonderful pattern in office that The Medical Society of New Jersey can ask for.

You know when we talk man to man, the word "love" comes to your tongue with difficulty. You don't quite get it out in the way I do with Louise, anyway. But I really want you to believe that as far as the little guy that I am following, I swear I think there is a great big element of love in my association with him. I'd like to salute him now. Thank you all for being at the head table in this gathering. Thank you. (Applause)

THE TOASTMASTER: Thank you, Jesse. I wish you had taken more time. We are ahead of schedule. (Laughter) Now I have to *ad lib* to fill in a little bit of space. But, you know, after all, we are here for a reason and that is to pay tribute to Clyde, and I have to do my share of this too, because I have known him for a long time, perhaps longer than anybody around here, except maybe Billy Costello. Nobody knows anybody longer than Billy Costello. But I have known him for twenty years and back to the time when I was an intern working for him, and he is a great guy. I want to tell you what a great guy he is. I remember distinctly in February 1941 when we had lobar pneumonia, a little epidemic, and we were giving serum and at that time there were twenty-six patients in the hospital in one week with lobar pneumonia, who had to have the serum every four hours, intravenously. We had two interns sick, too, on duty. I worked like a dog. Saturday afternoon came. He said I could have this afternoon off. I was supposed to. And I came back Sunday sick, myself, and he allowed me to sleep in bed that night until eight Monday morning.

I have not come to bury Caesar but to praise him and I will not labor his many faults, but rather at this time I will call upon someone who will bring to your attention some of his more desirable characteristics.

At this time I want to call on Dr. Kenneth Gardner, the immediate Past-President of The Medical Society of New Jersey.

DR. KENNETH E. GARDNER: Dr. Abraham, Our Honored Guests, Dr. and Mrs. Bowers, Ladies and Gentlemen: It is indeed a real pleasure for me to pay a well deserved tribute to our President, Dr. Bowers, for a job well done and to recognize the splendid contribution that he has made to our Society.

I must also hasten to include a very charming lady who, like all Presidents' wives, are the real unsung heroines of the medical profession—Mrs. Bowers. (Applause)

In his inaugural address last year, our President's keynote speech was entitled "Lead or Be Led," and on this theme he has been a constructive and positive leader. Dr. Bowers has given freely of his time and ability and, although one year is a relatively short period, he has contributed a great deal to the welfare of our Society and to the medical profession.

Dr. Bowers was active in so many endeavors that I am reminded of the two mosquitoes who were flying over the beach in Atlantic City and were admiring the scantily clad bathers. One mosquito said to the other: "I feel so frustrated. I know what to do, but I don't know where to begin." (Laughter) Dr. Bowers' many, many accomplishments leave me in somewhat the same situation.

Success for Dr. Bowers was assured at an early age. Although he was originally named Floyd C. Bowers, he quickly realized that, by observing such names as J. Pierpont Morgan, A. Wellington Pump, and U. Seymour Clearly, that the way to success for him was to be known as F. Clyde Bowers. I have been told also that by using the first initial and the middle name that it not only increases your prestige but it also guarantees to double your income. (Laughter)

During his year as President, Dr. Bowers conducted the affairs of this Society with tact, dignity and finesse and brought great honor to our Society. Having completed a most successful year, he may now assume that he can return to a quiet life at the fireside, to walk leisurely among the pastoral scenes of Mendham and to contemplate how to pick up the scattered remains of his practice. But this is purely a delusion. For having once been the President of The Medical Society of New Jersey and having made such a fine contribution to our Society, he will undoubtedly be called upon many times in the future to help with the ever-increasing problems of the medical profession.

And I am again reminded of another story about Mark Antony's visit to Cleopatra, when Mark said to Cleo, "And how are things?" and Cleo said, "Everything is just fine, Mark." To which Mark replied, "I'm certainly glad

to hear it, but I didn't come here just to talk." (Laughter)

Clyde, will you come up to the microphone?

Clyde, having been honored by your Society as its President, you now have the unique privilege of being eligible to join the Fellows of The Medical Society of New Jersey, and it is a real pleasure for me to present you with your Fellow's Key, to welcome you as a Fellow of The Medical Society of New Jersey, and on behalf of our Society to say thank you for a wonderful job well done. Congratulations. (Standing ovation)

PRESIDENT BOWERS: Thank you, Dr. Gardner.

Dr. Abraham, Honored Guests, Ladies and Gentlemen: Two years back when Lew Fritts was in this same position I remember him saying "This was one time that I don't need a script," and I believe that's true. It's the one time that we are at the end of the road and all we need to do is to say "Thanks." However, there are many, many people to whom I am indebted and it will be very difficult for me to name them individually, so I want to say thanks to all of you collectively. I want to thank the Woman's Auxiliary, the officers, Board of Trustees and the many committeemen who have served so well during the year, and the entire staff of The Medical Society of New Jersey.

However, I feel that, although I am getting on dangerous ground by picking out individuals, I would feel remiss if I did not mention a few of them by name. So I hope you will forgive me if I do thank a few people individually, and by doing this I certainly do not mean to neglect anyone.

First of all, I feel that I must thank my wife, Mrs. Bowers. (Applause)

Next I would like to thank Edith Madden, whose encyclopedic mind all of you people who have been interested in The Medical Society of New Jersey are aware of and without which we would find it difficult to get along. (Applause)

Her entire staff, her devoted group of girls, and we are very proud of them. They have done an excellent job at this convention, as they have at every convention. Thank you very much, young ladies. (Applause)

To our Executive Officer, Richard Nevin—a man with a great mind, a great capability, with oratory and wit, a fellow with whom I have had the pleasure of traveling around the State during the past year, and without whom I would have had difficulty attaining any success whatsoever. To you, Dick, my thanks. (Applause)

There always has to be someone who heads the inner circle of The Medical Society of New Jersey and this year that has fallen to Luke Mulligan who, as Chairman of the Board of Trustees, has done a splendid job. We have had more meetings this year than we have had in a long, long time, and this man has done a tremendous job and I want him to take a bow—Dr. Luke Mulligan. (Applause)

Probably one of my oldest friends and teacher, if there is such a thing in this business, and I don't mean in the professional aspect of medicine, but, if you want, in the politico socio-economic aspect of medicine—I certainly must bow to Billy Costello. (Applause)

And now to all the wonderful people in Morris County who have journeyed down here for the express purpose of paying tribute to Mrs. Bowers and myself—will you all please stand, from Morris County? (Applause)

And now I thank all of you once again. I want to assure you that the man succeeding me is a very capable individual. As I told you yesterday, Dr. Jesse McCall is one of my long time friends. We respect him, have a lot of love for him, and we know that The Medical Society of New Jersey is in good hands.

Thank you very much and good night.

(Standing ovation)

(The Toastmaster then introduced the guests at the head table.)

THE TOASTMASTER: Since we are trading literary classics back and forth, Dr. Gardner, I am reminded of a classic, too, about two Indians on the reservation, standing on the corner watching the girls go by, and one was, to say the least, a little bit unorthodox. Every time a girl went by he didn't say "How," he said "When?" Finally one of the fellows next to him said, "Aren't you a little mixed up?" He says, "I'm not mixed up. I know how, I want to know when." (Laughter)

And I guess this is when for me to bow off, too. There will be entertainment and dancing. (Applause)

(This portion of the program was concluded at 9:20 p.m.)

Announcements • • •

Course in Hand Surgery

A five-day, full-time course on surgery of the hand will be offered by New York University from March 6 to 11. This is designed mainly for general, orthopedic, plastic and industrial surgeons.

The class is limited to 40 participants and the tuition is $125. For applications, write to the Associate Dean, New York Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Ophthalmology-Otology Seminar

An unusual opportunity is offered to otologists, ophthalmologists and laryngologists to spend a few days in the Blue Ridge Mountains of Virginia and attend an intensive, practical colloquium in all aspects of these specialties. This is the 34th Annual Congress of the Gill Memorial Hospital in Roanoke, Virginia. The dates are April 3 through 8. For details, write to Dr. R. B. Harris at 711 South Jefferson Street, Roanoke, Va.

Graduate Courses in Ophthalmology

The New York Eye and Ear Infirmary announces the following graduate courses:

1. Ocular Surgery—April 24 to 29. Fee $225. Individual parts of the course may be taken at a prorated fee.
2. Histopathology of the Eye—May 1 to 6. Fee $100.
3. Practical Aspects of Perimetry—May 3, 4 and 5. Fee $40.

For registration, apply to Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Gastro-Intestinal Absorption

March 7, 1961, is the date for the Johns Hopkins colloquium on gastro-intestinal absorption to be held this year in New York City at the Sheraton Hotel. While advance registration is required, there is no fee. For forms, write to Robert S. Goodhart, M.D., at 149 East 78 Street, New York 21, N. Y.

Pediatric Oncology

An intensive course in pediatric oncology for general practitioners and pediatricians will be held April 26, 27 and 28 at the Memorial Hospital in New York City. Limited to 15 physicians, this intensive practical seminar will cover all aspects of diagnosis and management of tumors and related disorders in childhood. The fee is $35.

For further information write to Memorial Hospital, 444 East 68th Street, New York 21, N. Y.

Ophthalmology Fellowships Available

Fellowships for Residents in Ophthalmology have been announced by the Guild of Prescription Opticians of America. Applications must be received by May 15.

Each Fellowship is for a total of $1,800, payable in 36 monthly stipends. Grants are limited to residencies at approved institutions. Residencies may begin at any time during the calendar year. Application forms and further information are available from the Guild of Prescription Opticians of America, 110 East 23rd Street, New York 10, N. Y.

New Radiology Society

Applications are open for Charter Membership in the American Society of Diagnostic Radiology. Membership is open to cardiologists, chest physicians, gastro-enterologists, rheumatologists, orthopedists, pediatricians, otolaryngologists, internists and general practitioners who do or intend to do some types of diagnostic radiology in their offices.

For further information, please write to Dr. Eugene Greenwald at 100 Hollywood Avenue, Hillside, N. J.

American Board of Obstetrics and Gynecology

The next scheduled examination of this Board will be held in Chicago April 8 through 15. For further details write to Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

N. J. Doctors Elected to GE Office

At its annual meeting in October, 1960 the American College of Gastroenterology elected Dr. Henry Baker of Boston as President; Dr. Theodore S. Heineken of Glen Ridge as Vice-President; Dr. Louis L. Perkel of Jersey City as Secretary; and Dr. Christopher A. Beling of Montclair as Trustee.

September is Springtime in Brazil

The World Medical Association will meet in Rio de Janeiro in September. A luxurious cruise liner has been placed at the disposal of the Association for a 38-day cruise of the West Indies and South America, leaving New York on September 15. Doctors who want to attend the convention will find this a pleasant way of combining business with pleasure.

For details write to the World Medical Association, 10 Columbus Circle, New York 19, N. Y.

1961-62 MEMBERSHIP DIRECTORY

Is Your Listing Correct?

The 5th Edition of the bi-annual Membership Directory is scheduled for publication and distribution in the summer of 1961.

Make sure your listing is accurate and complete by checking your current listing and submitting any changes and/or additions PROMPTLY — in printed form—to the:

MEMBERSHIP DIRECTORY DEPARTMENT

THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton 5, N. J.

County Society Reports • • •

Atlantic

A regular meeting of the *Atlantic County Medical Society* was called to order on November 11, 1960 at the Children's Seashore House by our president, Dr. Harvey N. Vandegrift. The program chairman, Dr. Josiah C. McCracken, Jr., introduced the speaker of the evening. The essayist was his brother, Dr. Stewart McCracken, associated with Temple University Hospital and the Veterans Administration Hospital in Philadelphia. Dr. Stewart McCracken's subject was on the "Recent Advances in Cancer Chemotherapy."

Discussion on this paper was opened by Dr. Joseph Linsk.

Everyone was proud to applaud the efforts of a brother of one of our own colleagues.

The business meeting was a record one for brevity.

Dr. Morton Major reported in Dr. Victor Bressler's absence, that our Society is cooperating in Diabetes Detection Week.

Dr. Vandegrift announced that the State Department of Health would hold a "Symposium on Cancer in Children" in Atlantic City on November 17, with our own Medical Society of Atlantic County as co-sponsor.

The meeting was adjourned and some delicious refreshments and drinks were enjoyed by the Society.

LEONARD B. ERBER, M.D.

Reporter

Middlesex

The *Middlesex County Medical Society*, under the leadership of Dr. Stanley A. Gadek, M.D., president, held its regular meeting on November 16, 1960 at Roosevelt Hospital, Metuchen.

The Judicial-Medical Ethics Committee recommended for presentation to the Committee on Credentials of the Medical Society, the following applications for election to two-year Associate membership: Drs. George G. Brennan, Sayreville; Steven A. Frank, South River; Edward I. Panzer, New Brunswick; Philip A. Rosenfeld, Perth Amboy; Arthur B. Sherbin, East Brunswick; Edward P. Seizler, Sayreville; and Jacob Wolansky, Metuchen. To Regular membership by transfer from Marion County Medical Society, Fairmont, West Va.; Merle B. Davis, New Brunswick; and Herbert L. Weininger, Metuchen (Dr. Weininger transferred his membership from the Fulton County Medical Society, Atlanta, Ga.). To Regular membership from two-year Associate membership: James S. Wales, Jr., Perth Amboy; and Joseph Zawardsky, South River.

The dues for 1961 are to be the same amount as last year without the five dollar credit allowance.

The May 1961 meeting date was changed to the fourth Wednesday of the month so as not to conflict with The Medical Society of New Jersey's Annual Meeting.

Dr. Joseph Gannon, representing The Medical Society of New Jersey, gave a spirited talk and answered many questions on the New Jersey "Relative Value Index."

The meeting was adjourned and collation served.

THOMAS I. STEINBERG, M.D.

Reporter

New Jersey Society of Internal Medicine

The *New Jersey Society of Internal Medicine* on November 18, 1960 met at Princeton and elected officers for 1961. This Society is the New Jersey Branch of the American Society of Internal Medicine.

Officers elected were: President: Albert Abraham, M.D., Morristown; Vice-President: John H. Winslow, M.D., Maplewood; Secretary: John J. DeLaney, M.D., Morristown; and Treasurer: Donald P. Burt, M.D., Morristown.

Elected to the Council were Doctors Joseph Gardam, Harry Kaplan, John Kinczel, Johannes Pessel, Irvin Sussman, John J. DeLaney, Donald P. Burt and James Gleason.

JOHN J. DELANEY, M.D.

Secretary

Letters to The Journal • • •

"An Article in Need of a Cathartic"

Dear Sir:

The November 1960 JOURNAL of The Medical Society of New Jersey contains an article "Psychosomatic Aspects of Constipation." The author evaluated an emotionally unstable, middle-aged woman with the chief complaint of constipation. Using references to Freud, Cannon and Franz Alexander, evaluation of social factors and dream material, the author decided (from his frames of reference) to recommend an amine oxidase inhibiting drug to alter the personality in order to relieve the presenting symptom. However, he neglected to advise the referring physician that the drug he chose is one which might make her feel less depressed but which, in itself, is constipating. A judicious prescription of Cascara Sagrada would leave both patient and article less full of the matter concerned in the chief complaint.

IRA S. ROSS, M.D.

Dear Sir:

Dr. Ross raises an interesting point. There is often a great difference however between theoretical secondary effects of a compound and its actual behavior in clinical situations.

Nardil® (beta-phenylethylhydrazine) is a sympathomimetic amine and monoamine oxidase inhibitor. As such, anti-cholinergic effects might be anticipated to a greater or lesser degree.

My own experience with at least 50 patients on the drug has failed to uncover one case in which a recipient complained of constipation as a side effect. Thals' study of 180 cases (*Diseases of the Nervous System*, 20:5, May, 1959) does not even mention this symptom. Evans, in an analysis of 161 patients to be published in *Psychosomatics*, observed that depressed subjects suffering with alternating constipation and diarrhea were consistently relieved of both. Dr. C. V. Fisher of Warner-Chilcott advises me that in statistics compiled on the use of Nardil® in 2696 patients, the incidence of constipation as a side-effect was 2.3 per cent. This is probably somewhat less than in the general population.

SANFORD M. LEWIS, M.D.

Medicine's Newest Occupational Hazard

Dear Sir:

The practice of medicine was born and flourished with the faith of the sick. Early faith was based upon superstitions, belief in magic and the religions, which nurtured and sponsored medicine. As medicine became an art and stood on its merits, the sick held its faith not in what medicine could do for them but in the man healing them.

Wars, atheism, selfishness, over-abundance and many other factors are now changing this hallowed concept. Gradually, people are coming to think of medical care as a commodity which they demand for a consideration. They expect the same "warranty" which they associate with an automobile or television set. Any alteration in this "implied contract" they feel needs guarantee legally as in other commodities. Hence, in this liability and insurance conscious world, we have a considerable upsurge in malpractice suits.

Spectre of malpractice suits is influencing the practice of medicine to a point where ultra-conservatism, fear and refusal of medical care will greatly impair the future of as well as the quality of medical care.

No art or science hampered by fear of lawsuits can flourish. At this juncture, we need the help of the legal profession. The bar and the legislature came through with workmen's compensation laws to help American industry expand in spite of some of the problems we are facing. Therein lies a possible solution.

The medical and legal professions will have

to agree that occupational hazards exist in our profession. Just as laws were enacted to protect industry against that hazard, so are similar laws needed to protect the medical profession against occupational hazards.

The public must be educated to the fact that medical care cannot be standardized like plastic bolts; that variations in the quantity and results of care are inevitable in anything that works with human beings. Since we sell services rather than a product, variability is to be expected. Machines may attain precise standardization—but even there, accidents happen. Some understanding of the variability of medical results must be transmitted to the public. Perhaps this might counteract the indemnity-consciousness which is now tainting doctor-patient relationships.

Unless some such plan is adopted, bold doctors will be afraid to practice medicine and we may degenerate to the safe, harmless and ineffective medicine of the dark ages. The public and their law-makers have the next move!

A. L. Cantelmo, M.D.

Book Reviews

Anatomy: A Regional Study of Human Structure. Ernest Gardner, M.D., Donald Gray, Ph.D. and Ronan O'Rahilly, M.D., with illustrations by Casper Henselmann. Philadelphia, 1960. Saunders. Pp. 999. ($15.00)

The standard, large-sized anatomy text is the basis of medical education. It is, however, too bulky, too detailed, too unrelated to living function to be useful to the clinician. By contrast the digest, compend or outline volume is too sketchy. Doctors Gardner, Gray and O'Rahilly have plugged the gap with this up-to-date book. Emphasis is on "living anatomy," and many x-ray pictures are included. An unusual glossary of eponyms is found in the appendix. In addition to the traditional systemic treatment, the authors include a regional approach: neck, chest and so on. Enough embryology and physiology are included to lend interest. The chapter on "radiologic anatomy" is valuable and unique. The text is not as profusely illustrated as the more conventional anatomy book, but the cuts are very good and make structural relationships stand out clearly. Paper and binding conformed to the usual Saunders standards. All in all, this is an excellent clinician's textbook of anatomy.

Henry A. Davidson, M.D.

PQRST: A Guide to Electrocardiogram Interpretation. By Joseph E. F. Riseman, New York 1960. Macmillan. Ed. 4. Pp. 168. ($6.50)

This practical guide underwent extensive revision during the eight years which have passed since publication of the previous edition. It was enlarged from 123 to 167 pages. Written for the beginner, it is not intended to replace standard textbooks. However, it now includes, in condensation, most of the areas covered by regular textbooks, with a focus on the practical rather than the theoretical. This emphasis is essential for the realization of the purpose of the book: the actual interpretation of the ECG.

Unlike most authors, Riseman starts with the unknown tracing. From there the reader reaches the correct electrocardiographic diagnosis. The author uses this approach rather than starting with a discussion of the patterns found in various cardiac conditions.

The teaching value of this book is enhanced by the current revision of the text. It clearly elaborates the values and limitations of the ECG and the special significance of each of the twelve leads (for the overall interpretation).

Basic information is in bold print, italics, or clearly enumerated. This saves time for the be-

ginner who would otherwise be lost trying to single out such basic information from larger textbooks. The information is condensed but comprehensive. The text does not try to oversimplify the task of interpretation.

Besides a considerable change in nearly every part, the coverage of many conditions is considerably expanded, as, for instance, in the discussion of electrolyte imbalance. There are several new fields covered; *e.g.* differential diagnosis and normal variations simulating electrocardiographic abnormalities.

The book presents more than 50 figures, 10 tables, and 60 diagrams drawn to scale from original tracing, and 35 typical cases, many illustrated by twelve lead original tracings.

There is no alphabetical index, but this should be considered for future editions of this useful manual.

MANFRED KANTHER, M.D.

The House of Orchids By Hazel Lin. M.D. New York 1960. The Citadel Press. Pp. 186. ($3.50)

The author, Dr. Lin, is a member of our Hudson County Medical Society. At one time she was a medical inspector for a Chinese brothel and the present novel is based on the life story of one of the girls who sold herself to get the money to support her orphaned brothers; of reciprocal love between herself and a handsome, respectable customer; and of the obstacles to the consummation of that love. The book gives a sensitive insight into the daily lives of the poor people of China.

FELIX A. UCKO, M.D.

Current Surgical Management II. Edited by John H. Mulholland, M.D., Edwin H. Ellison, M.D. and Stanley R. Friesen, M.D. Philadelphia 1960. W. B. Saunders Company. Pp. 348, illus. ($8.00)

This is a book of alternative viewpoints on certain controversial surgical problems. It is an extension of Volume One. Some fifty contributors have participated in making this book most interesting and fascinating reading. It is not a "textbook," and no attempt has been made to cover the entire field of surgical activity. It does not provide the answers—it simply demonstrates, in a clear, concise manner how certain authorities arrived at their own answers.

The subjects are presented with some approximation to the magnitude of the problem in a general surgeon's experience, rather than according to regional anatomy, as is usually found in conventional books on surgery. Each topic is followed with a "summary" or "conclusion," and detailed references, should one wish to pursue the matter further. All the articles are well written, clear and concise. This book makes excellent collateral reading for any active surgeon. It is an exceedingly valuable reference work for the surgeon confronted by any of the numerous controversial problems discussed therein.

Although *Current Surgical Management II* cannot be called a "must" for the surgeon's library, it shou'd rank high in its desirability, for it presents many interesting problems, thoroughly and completely discussed in a most interesting and informative manner.

DAVID B. ALLMAN, M.D.

Communicable and Infectious Diseases. Franklin H. Top, M.D. with 22 collaborators. St. Louis, 1960. Mosby. Pp. 810 with 15 color plates and 123 figures. Ed. 4. ($20.00)

Originally offered as a handy reference volume for all whose duties necessitated contact with communicable diseases, this solid work has been a popular manual for 19 years. This is the fourth edition. There is new material here on poliomyelitis, leprosy, hospital and home management of communicable disease and on the common cold. The book includes a unique glossary and a swift reference table of diseases, with incubation period, quarantine data and so on. For each disease, an up-to-date treatment regime is carefully spelled out. All in all, this deserves its reputation as a standard text in the important, interesting and prognostically hopeful field of communicable diseases.

ULYSSES FRANK, M.D.

Basic Facts of Body Water and Ions. By Stewart M. Brooks, M.S. New York 1960. Springer. Pp. 160. ($2.75)

This 160-page booklet presents the elementary facts of water and electrolyte physiology. Apparently designed for the high school or nursing school level, it includes a fundamental discussion of the acid-base balance, various solutions, maintenance therapy, problems of edema, acute renal failure and fluid balance studies as related to the infant.

From the reviewer's viewpoint, there were gross violations of teaching principles noted under paragraph heading "Isotonic Sodium Chloride." Mr. Brooks states that this solution is also referred to as physiologic saline and normal saline. This is basically unsound terminology and unacceptable in modern biochemical discussions.

The author's definition of a base simply as an "acceptor of hydrogen" seems to the reviewer somewhat rigid and opinionated. Certainly, bases can be identified in more than one way biochemically.

The excursion made by the author into therapy is, in general, basically sound, except for the statement: "The daily salt requirements (sodium) do not have to be met for two to five days following surgery or other traumatic situations." This is a highly controversial statement.

The booklet includes a glossary and an index. It is the reviewer's opinion that this brochure will not ring any bells in the world of biochemistry, though it could be perused with profit to the elementary student.

THOMAS K. RATHMELL, M.D.

Medical Department, United States Army. Surgery in World War II. Neurosurgery Volume II. Edited by R. Glen Spurling, M.D. and Barnes Woodhall, M.D. Washington, D. C. 1959. Department of the Army. U.S. Government Printing Office. ($7.00)

This historical manuscript of the neurosurgical series deals with injuries of the spinal cord and peripheral nerves. The trauma sustained by healthy young men was unfortunate, but the data here collected and analyzed has added a great deal to the treatment of similar accidents in civilian life. The management and treatment of military personnel during the war is somewhat different than the attention given in civilian life.

It was believed, in anticipation, that the outstanding neurologic problems would be head injuries; yet peripheral nerve injuries constituted more of a problem. This report consisted of 1,260 cases of wounds of the spinal cord. Surgery was indicated only when bony impingement was present or there was doubt as to complete destruction of the cord. The analysis of surgical cases revealed 15 per cent improved within 48 hours. The other indications were the repair of cerebrospinal fluid leaks to prevent infection and to remove bony chips of foreign bodies to eliminate root pain.

Surgery for intervertebral disc became more selective by the end of the war. Only those who desired surgery and had intractable sciatic pain were considered. Otherwise, under stress there was recurrence of symptoms and the use of much needed personnel. In peripheral nerve injuries, optimum time for repair was within 21 to 90 days. This time delay was to permit a decrease in the edema and vascularity. More than 3,656 operations were recorded in the Peripheral Nerve Registry. At the time of injury only coaptation or protection of divided nerve ends was advised.

This volume provides a method of recording and evaluating specific types of injury. Unlike the experience of World War I, the management of peripheral nerve injuries correlated with a 10-year follow-up has not been lost.

ARTHUR WINTER, M.D.

Experiments and Observations on the Gastric Juice and the Physiology of Digestion. By William Beaumont, M.D. Facsimile of the original edition of 1833 together with a biographical essay, 'A Pioneer American Physiologist,' by Sir William Osler. New York 1959. Dover Publications, Inc. Heavy paper covers. ($1.50)

This American medical classic, now reissued in an inexpensive edition, is a landmark in the physiology of digestion. Third in Dover's series of reprinted medical classics (following Clendening's *Source Book in Medical History*, and Camac's *Classics of Medicine and Surgery*), Beaumont's study of Alexis St. Martin remains a unique examination of man's knowledge of his body processes. The account of a Canadian trapper's gunshot-wound gastric fistula and accurate observations recorded by his U. S. Army surgeon still makes informative and inspirational reading. This paperback edition republishes the original work together with a reprint of Dr. William Osler's address on Beaumont delivered before the St. Louis Medical Society in 1902. (The Beaumont Room in the library of the Washington University School of Medicine at St. Louis, today appropriately recalls Dr. Beaumont's life and work.)

In addition to the scientific value of Beaumont's careful studies, performed in the backwoods of Michigan, this book brought favorable European recognition for American medicine in its pioneer period. Few works have had such a valuable and lasting effect on physiology and medicine.

Of the author, Osler noted, "His work remains a model of patient, persevering investigation, experiment, and research . . . Beaumont is the pioneer physiologist of this country, the first to make an important and enduring contribution to this science."

This reprinted volume, with Osler's fine biographic sketch of William Beaumont, is a valuable addition to Dover's growing series of reissued primary sources in medicine.

FRED B. ROGERS, M.D.

A Head, A Heart and Two Big Wheels. By Jules Saltman. New York 1960. Public Affairs Committee. Pp. 28. Paper. ($0.25)

Under this eye-catching title, here is a brochure on paraplegia. Mr. Saltman describes how, with modern technics, thousands of paraplegics are now leading almost normal lives. The booklet was prepared in cooperation with the National Paraplegic Foundation. It describes in clear language the causes of paraplegia and the treatment methods available. Although it pulls no punches, it is hopeful in outlook. This is an excellent pamphlet to give to the family of a new paraplegic. It may be purchased for 25 cents from the Public Affairs Committee, 22 East 38 Street, New York 16, N. Y.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JANUARY, 1961 • VOL. XXXIV, NO 1

RESULTS OF THE TREATMENT OF TUBERCULOSIS BEFORE AND SINCE THE INTRODUCTION OF CHEMOTHERAPY

The prognosis of many forms of tuberculosis is greatly improved when at least two drugs are administered for a period of eighteen months. Relapse is also less frequent than in the pre-chemotherapy era.

The proper administration of chemotherapy has led to a striking improvement in the outcome of the treatment of tuberculosis. If, however, patients with active disease have received inadequate chemotherapy, the cure rate will be lower and the relapse rate higher. All new cases of active tuberculosis, irrespective of the site, should receive combined continuous chemotherapy for about 18 months or longer. Bed rest is indicated during the early active phase and, in certain selected cases, surgical measures are also necessary.

Three antimicrobial agents have proved to be of great value, namely, isoniazid, streptomycin, and para-aminosalicylic acid (PAS). It is generally agreed that these drugs should not be prescribed alone, but should be given in a combination of at least two. If any one of them alone is prescribed to a patient with open cavitary disease, the tubercle bacilli in the host rapidly develop resistance to the drug, so that it is no longer effective in combating the tuberculous infection. If, on the other hand, two or all three of the antimicrobial agents are given concurrently, the development of resistance by the tubercule bacilli to the drugs administered is markedly delayed, and the drugs continue to be effective in combating the infection for a much longer period.

H. E. Pugsley, M.D.; E. A. Allen, M.B., Ch.B.; O. T. Cheung, M.B.; H. S. Coulthard, M.B., and G. L. Gale, M.B., *The Canadian Medical Association Journal, August 27, 1960.*

ISONIAZID ESSENTIAL

Although there is not much difference in the effect of the different combinations, it is generally agreed that isoniazid should be one of the drugs given. It has established itself as the most powerful agent in the treatment of tuberculosis.

In assessing the results of the modern treatment of such a chronic disease as tuberculosis, we are handicapped by the fact that adequate chemotherapy, as we know it, has been in use for little more than seven years—insufficient time for an adequate long-term follow-up. However, since relapses usually occur within a period of five years, the results here reported should be a fair indication of the ultimate prognosis.

Before antimicrobial therapy was available, the mortality rate of active pulmonary tuberculosis was estimated to range from 5 per cent in minimal cases to 20 per cent in moderately advanced disease and to 70 per cent in far advanced. The majority of patients with persistent cavitation died within five years.

Modern treatment has resulted in a striking reduction in mortality and relapse rates. At the Toronto Hospital for Tuberculosis we have analyzed the results of treatment of all patients with active pulmonary tuberculosis who were admitted to that hospital in 1953, who had sputum positive for tubercle bacilli, who had not been given antimicrobial therapy before, and who were administered streptomycin, isoniazid and PAS continuously for at least nine months. The average duration of triple-drug therapy given to the 140 patients in the series was 17 months.

At the end of five years, six patients had died, or 4 per cent of the total. All the deaths were in the far advanced group. With adequate chemotherapy, and resectional surgery where indicated, the mortality was strikingly reduced as compared with the prechemotherapy estimates of from 5 per cent (minimal) to 70 per cent (far advanced).

Of the 25 cases of minimal tuberculosis in the series, 100 per cent had attained inactive status by the end of two years, while 97 per cent of 61 moderately advanced cases had become inactive by the end of three years, and 81 per cent of 54 far advanced cases had become inactive by the end of three years. (Inactive, as defined by the National Tuberculosis Association, means that the following conditions had been met for at least six months: repeated examinations of the sputum for fasting gastric contents are negative for tubercle bacilli on culture; the chest radiographs have remained stable in appearance, and there is no evidence of cavitation.) It is evident that if cases of minimal or moderately advanced disease are adequately treated with drugs, one can be confident that the process will in almost all cases become inactive within two years. With far advanced disease, however, a favorable outcome is less certain.

RELAPSES

In an attempt to find out how many patients relapse after attaining an inactive status, 125 of the 140 cases were followed from two to five years. It was found that 4 per cent had relapsed in the period of follow-up. In a series of 900 cases treated without chemotherapy, or inadequate chemotherapy, reported by the Veterans Administration Hospital, Memphis, Tenn., 30 per cent had relapsed at the end of three years. The 4 per cent figure has also been reported by the Fitzsimons Army Hospital, Denver, for 2,500 patients adequately treated with drugs and followed from one to five years.

It must be noted that the presence of a persistent cavity in the lung is always a great menace to the patient, whether he has had chemotherapy or not. The presence of a cavity in the lung that has failed to close after six to eight months of chemotherapy is the cardinal indication for surgical resection.

In the Toronto Hospital series, pulmonary resection was performed in 31 cases, or 22 per cent. The resection was segmental in 20 cases; a lobectomy was performed in 10 cases, and a pneumonectomy in one case. All these surgically treated cases became inactive; there were no deaths, but one relapse occurred.

Adequate chemotherapy in bone and joint tuberculosis has resulted in a marked reduction in mortality, more rapid subsidence of active disease, decrease in length of hospital stay, and marked reduction in relapse rate. Nearly half the cases are discharged with movable joints.

Four groups of cases of renal tuberculosis have been followed. In the first group of 82 patients who had neither chemotherapy nor nephrectomy, 58 per cent died of tuberculosis. In the next group of 347 cases treated by nephrectomy but without chemotherapy, 46 per cent died of tuberculosis. Inadequate chemotherapy in 175 cases led to a moderate reduction of mortality, but in the last group of 163 cases, adequate chemotherapy resulted in a striking reduction in the mortality to 1 per cent and a relapse occurred in only 1 per cent of this group.

SUMMARY

The outcome of modern treatment has been compared with that before the use of chemotherapy. Although the follow-up period is not long enough for final assessment, it is evident that combined continuous administration of isoniazid with PAS or with streptomycin, or all three drugs, for 18 months or longer, has resulted in a striking reduction in the mortality rate and improvement in the relapse rate.

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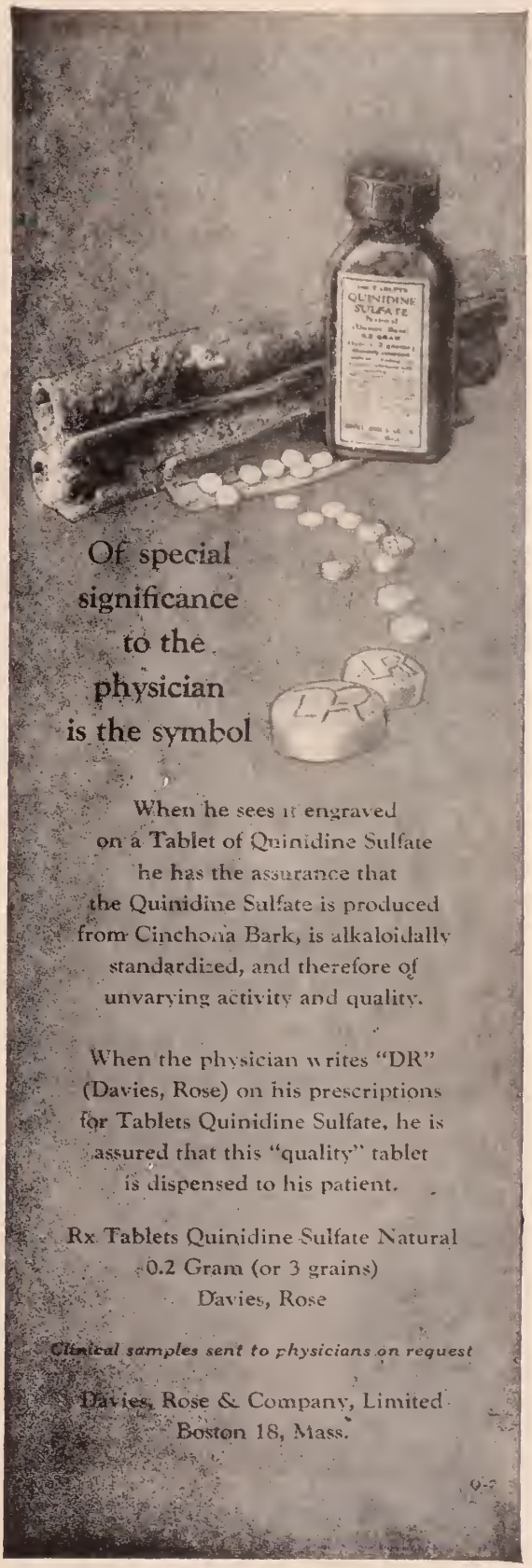
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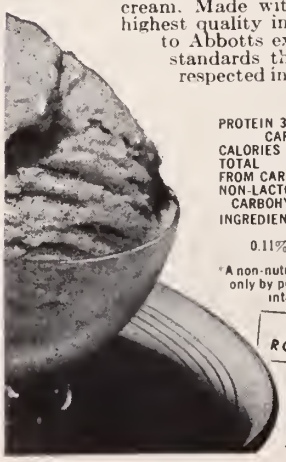
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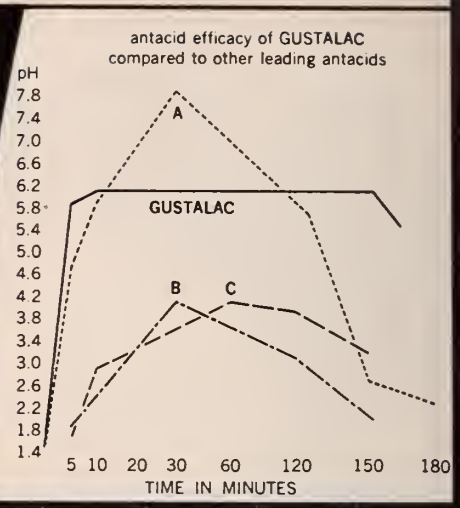
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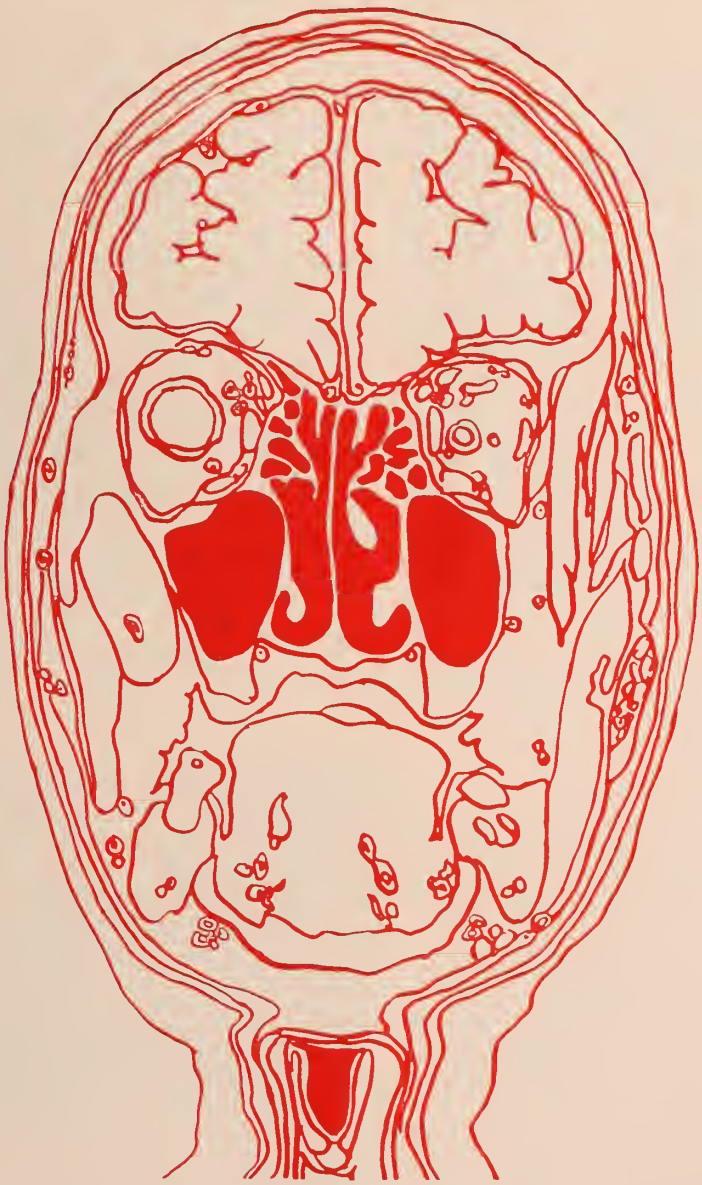
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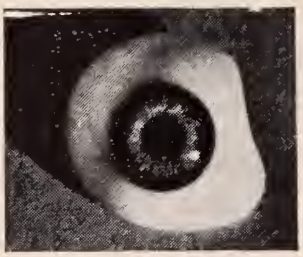
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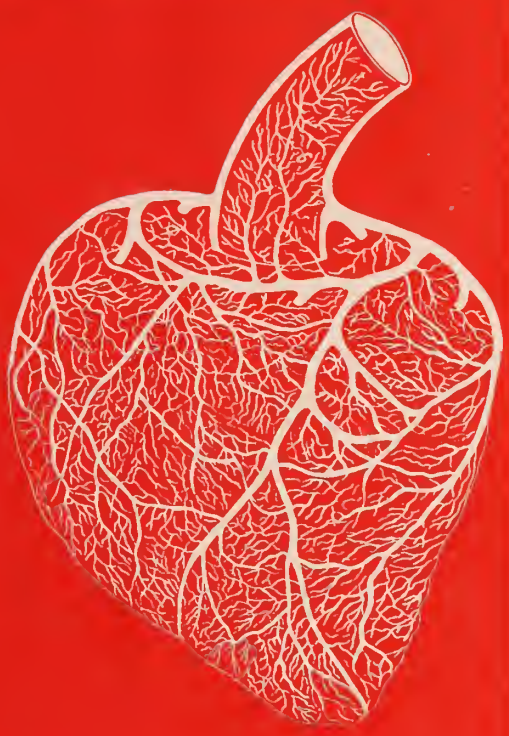
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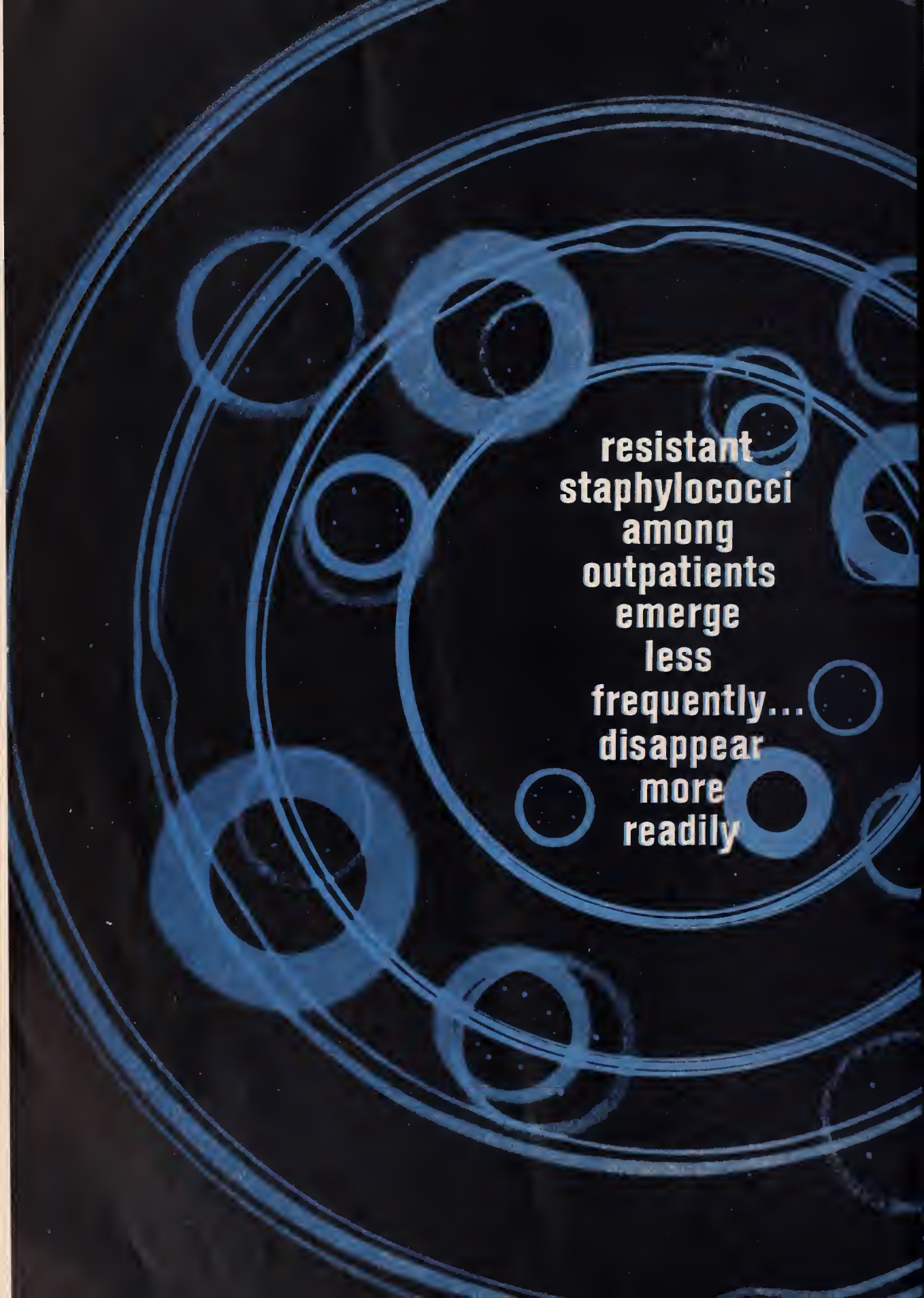
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Second Class Postage Paid at Orange, N. J.

VOL. 58, No. 2 FEBRUARY, 1961 Subscriptions, $3.00 per Year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

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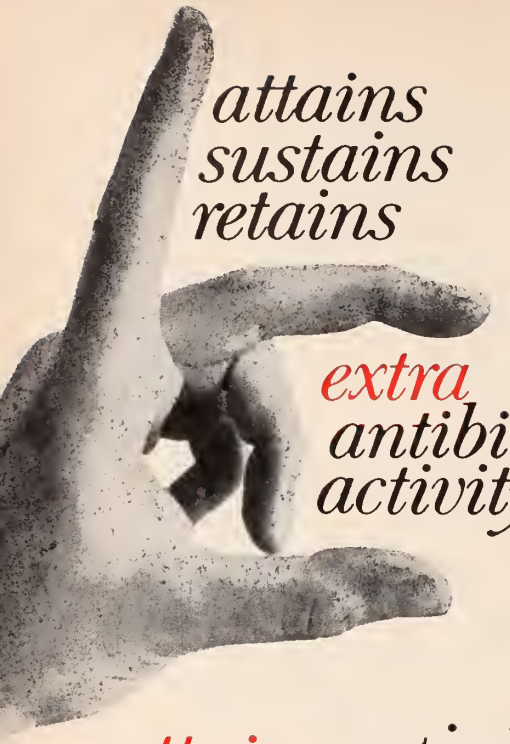
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attains
sustains
retains

extra
antibiotic
activity

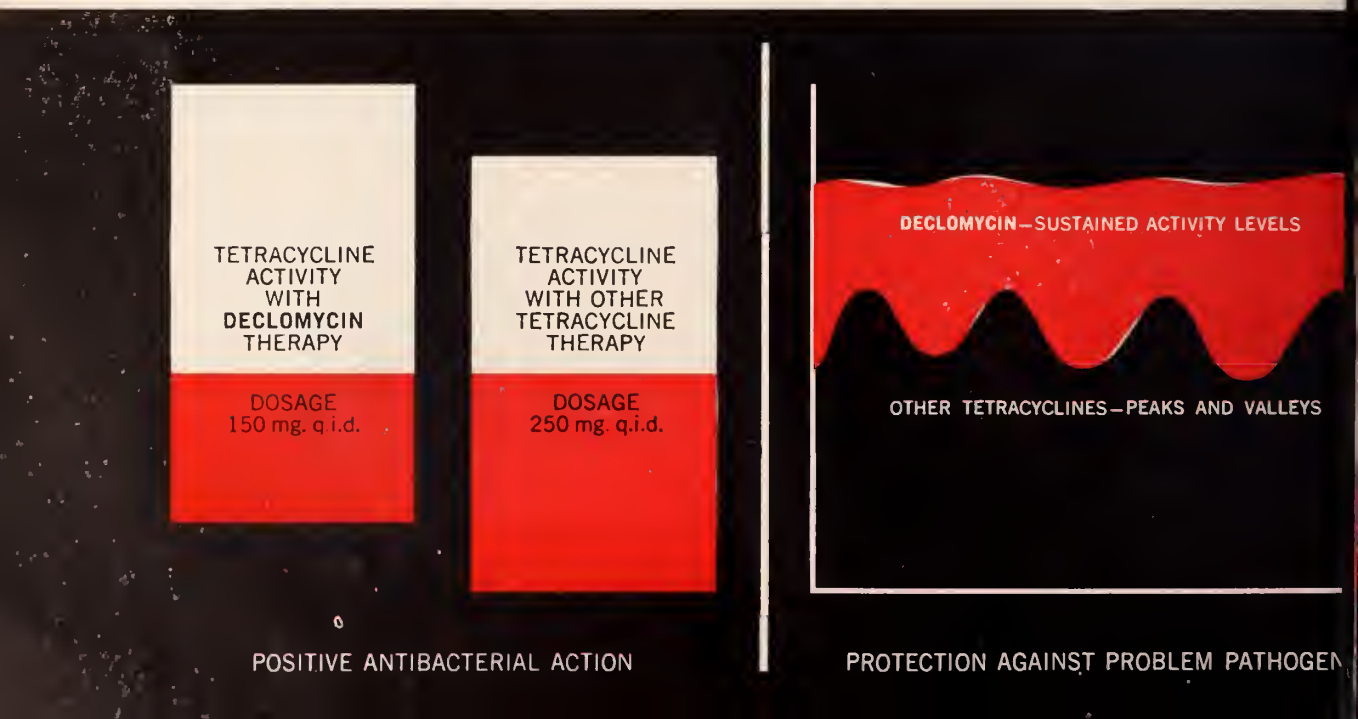
DEC

attains activity levels promptly

DECLOMYCIN Demethylchlortetracycline attains—usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline su
through the entire therapeutic course, the high
ity levels needed to control the primary infecti
to check secondary infection at the original
another—site. This combined action is usual
tained without the pronounced hour-to-hour, d
dose, peak-and-valley fluctuations which c
terize other tetracyclines.

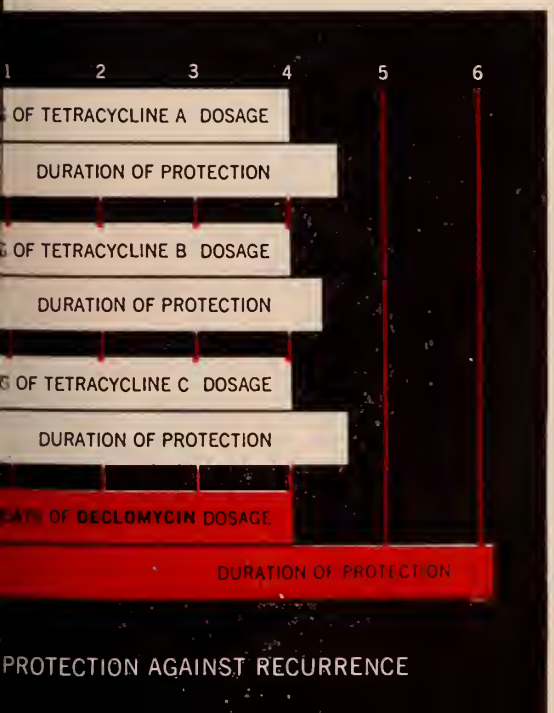


LOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

ins activity
els 24-48 hrs.

MYCIN Demethylchlortetracycline retains ac-vels up to 48 hours after the last dose is t least a full, extra day of positive action may confidently expected. The average, daily adult for the average infection—1 capsule q.i.d.—ame as with other tetracyclines...but **total** is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

Lederle

LEDERLE LABORATORIES
A Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York



Lifts depression...as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety...rapidly and safely

Balances the mood – no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety – both at the same time.

Acts swiftly – the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function – frequently reported with other antidepressant drugs.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

▲Deprol▲®

WALLACE LABORATORIES / *Cranbury, N. J.*



in infectious disease[17,22,30,36]
in arthritis[18,19,20,29]
in hepatic disease[2,3,4,5,38]
in malabsorption syndrome[1,2,6,27]
in degenerative disease[6,7,19,20,40]
in cardiac disease[23,26,29,38,41]
in dermatitis[24,39]
in peptic ulcer[8,21,38]
in neuroses & psychiatric disorders[25,28]
in diabetes mellitus[21,32,33,38]
in alcoholism[9,11,35,37,38]
in ulcerative colitis[10,14,16]
in osteoporosis[13,19,20]
in pancreatitis[15]
in female climacteric[12,34]

Patients with chronic disease deserve the nutritional support provided by

Theragran-M

Squibb Vitamin-Minerals for Therapy

11 vitamins, 8 minerals
clinically-formulated and potency protected to provide
enough nutritional support
to do some good

with vitamins only
Theragran
also available:
Theragran Liquid
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Theragran products do not contain folic acid.

1-41 a list of the above references will be supplied on request.

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Squibb Quality—the Priceless Ingredient

THERAGRAN® IS A SQUIBB TRADEMARK

BRONCHI AT EASE—DAY AND NIGHT

New Isuprel Compound Elixir, with a pleasant vanilla flavor, keeps the bronchi dilated in patients with asthma and chronic bronchitis. Isuprel Compound Elixir permits easy breathing, prevents bronchospasm, promotes expectoration and reduces wheezing or disturbing allergic or bronchitic cough.

Isuprel Compound Elixir is a balanced expectorant bronchodilator. It provides three bronchodilators, **Isuprel, ephedrine** and **theophylline,** with the expectorant **potassium iodide** in one palatable mixture. It also contains **Luminal®** to negate any possible side effects from the adrenergic medication and to provide a mild sedative effect. Isuprel Compound Elixir makes patients more serene by preventing or alleviating symptoms and prolonging relief, day or night.

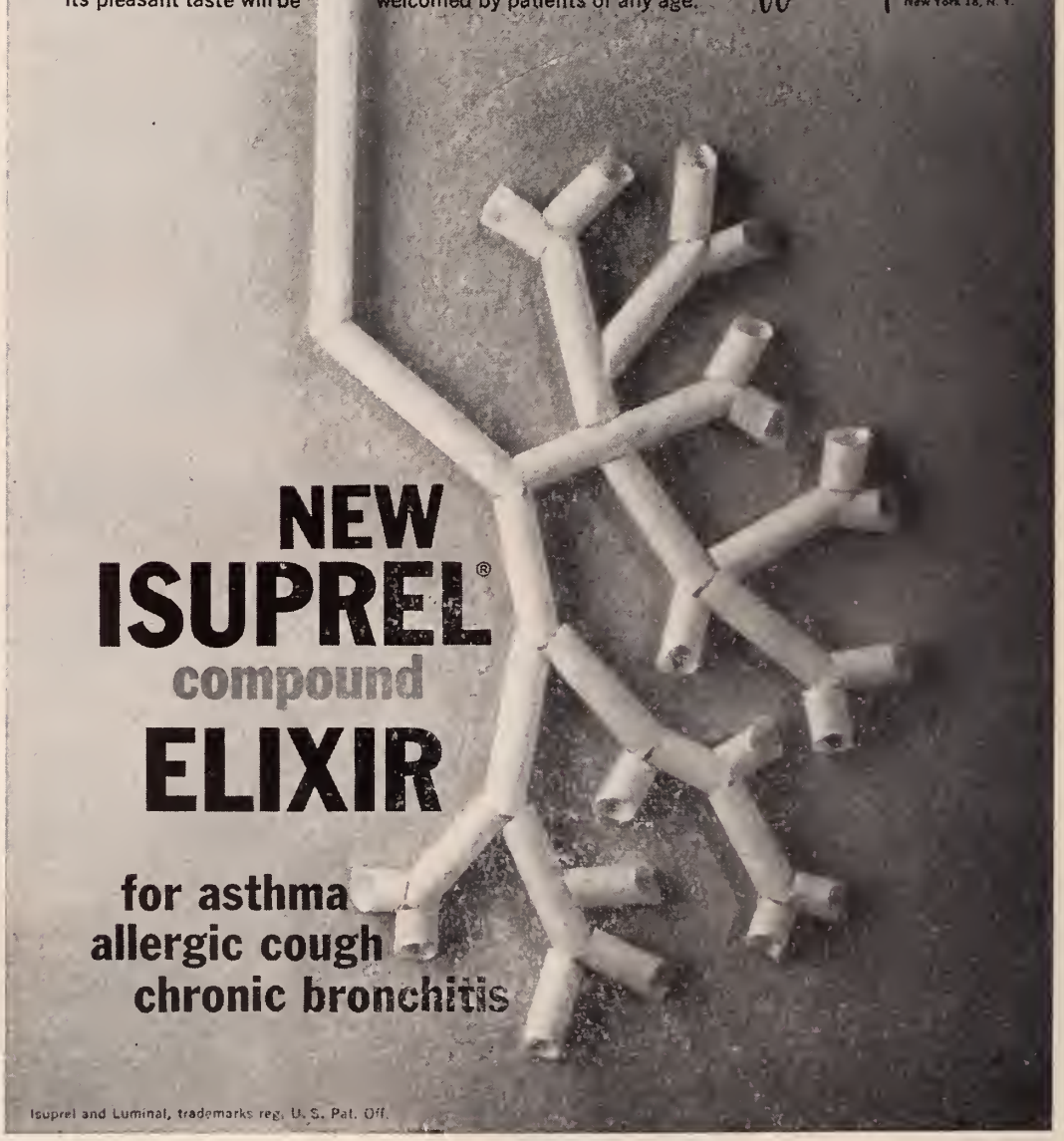
Isuprel Compound Elixir is especially suitable for children, but its pleasant taste will be welcomed by patients of any age.

Each tablespoon (15 cc.) contains:

Isuprel (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal (brand of phenobarbital)	6 mg.
Alcohol	19%

Dosage:
Children—from 1 to 3 teaspoons (5 to 15 cc.) three times daily as required. Adults—1 or 2 tablespoons (15 to 30 cc.) three or four times daily as required.

Winthrop LABORATORIES New York 18, N. Y.

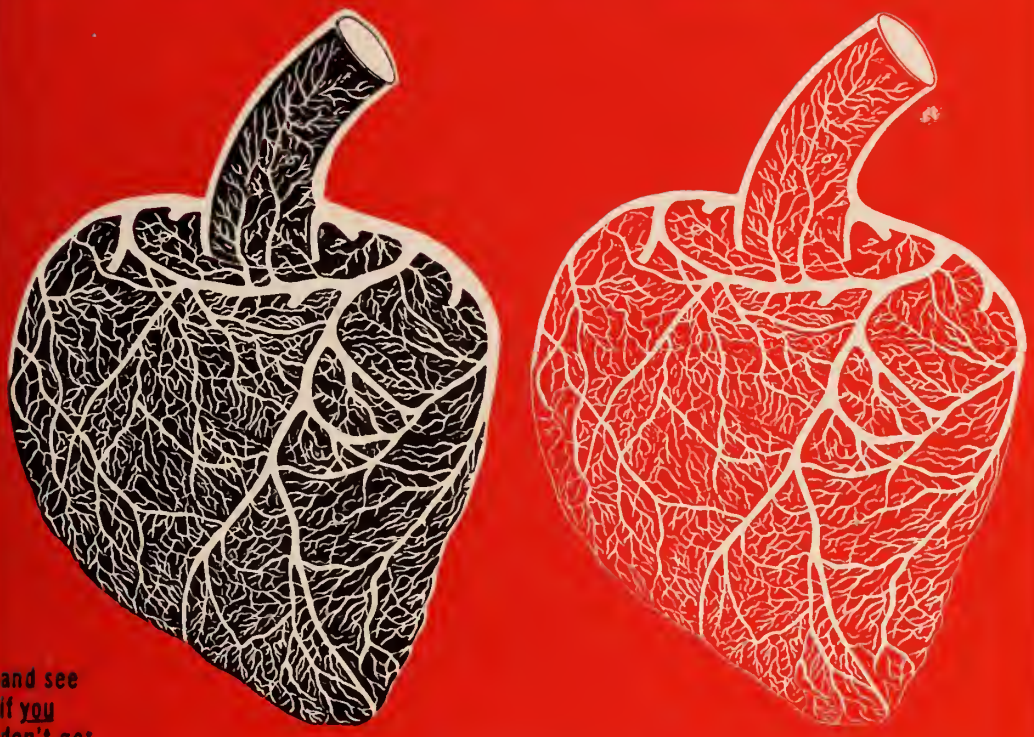


NEW ISUPREL® compound ELIXIR

for asthma allergic cough chronic bronchitis

Isuprel and Luminal, trademarks reg. U. S. Pat. Off.

combine two basic approaches to angina pectoris... **ALLAY ANXIETY... PROMOTE VASODILATION**



and see if you don't get a response like this: **CARTRAX REDUCES "LENGTH, SEVERITY AND AMOUNT OF ANGINA PECTORIS" IN ANXIOUS CARDIACS***

Clark treated 31 anginal patients who showed signs of anxiety, fear, excitement and other forms of emotional stress. On CARTRAX, all 31 fared better than they had on previous therapy... as judged both by subjective reports and by reduced nitroglycerin requirements.*

CARTRAX combines PETN (for prolonged vasodilation) with ATARAX (the tranquilizer preferred for angina patients because of its safety and mild antiarrhythmic properties). Thus, CARTRAX helps you to cope with both components of angina pectoris—circulatory and emotional.

For a better way to help your angina patients relax, prescribe CARTRAX.

*Clark, T. E., in press.

CARTRAX®

PETN†+ATARAX®†† **Dosage:** Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. ATARAX) 3 to 4 times daily. For dosage flexibility, CARTRAX "20" (pink) tablets (20 mg. PETN plus 10 mg. ATARAX) may be utilized at a level of one tablet three to four times a day. The tablets should be administered before meals for optimal response. For convenience, write "CARTRAX 10" or "CARTRAX 20." As with all nitrates, use with caution in glaucoma. **Supplied:** In bottles of 100. Prescription only.

†pentaerythritol tetranitrate ††brand of hydroxyzine

Rx

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

new clinical study[1] cites beneficial results in over 90% of cases in dry, itchy, scaly skin with Sardo®

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Use of **SARDO** in 118 dermatological patients to relieve dry, itchy, scaly, fissured skin achieved these excellent results:

CASES	AFTER SARDO*		
	Excellent	Good	Poor
49 Senile skin	32	13	4
26 Dry Skin in younger patients (diabetes, etc.)	14	11	1
20 Atopic dermatitis	8	10	2
13 Actinic changes	9	4	—
10 Ichthyosis	3	4	3
Skin Conditions	Benefited	No Benefit	
20 Nummular dermatitis	19	1	
10 Neurodermatitis	10	—	



SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

SARDO releases millions of microfine water-miscible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Bottles of 4, 8 and 16 oz.

1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

*patent pending
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Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
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They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
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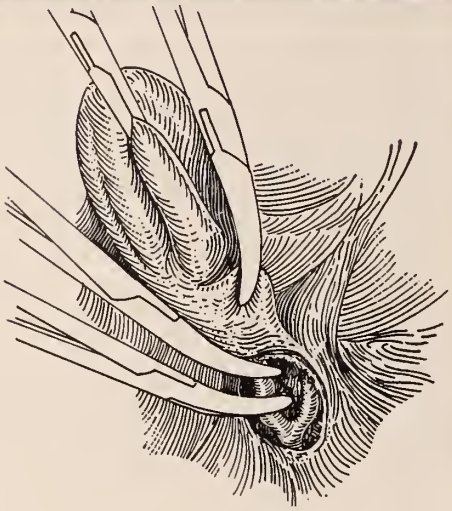
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HOW MAY A PATIENT BE REASSURED THAT REMOVAL OF HIS GALLBLADDER WILL NOT SERIOUSLY IMPAIR HIS DIGESTIVE ABILITY?

He may be told that, among animals of similar dietary habits and digestive processes, some have a gallbladder and some do not. Among the herbivores, the cow and sheep have one, the deer and horse do not; among the omnivores, the mouse has one but the rat does not.

Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

when the patient

needs

increased bile flow...

DECHOLIN®

(dehydrocholic acid, AMES)

"Constant loss of bile [from relaxation of sphincter of Oddi following cholecystectomy] reduces the amounts available for lipid absorption after meals, with resulting clinical symptoms apparently relieved by bile acid administration." *Source:* Popper, H., and Schaffner, F.: Liver: Structure and Function, New York, McGraw-Hill 1957, p. 309.

Available: DECHOLIN Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.). Bottles of 100, 500, and 1,000.

and for hydrocholeresis plus *spasmolysis*...

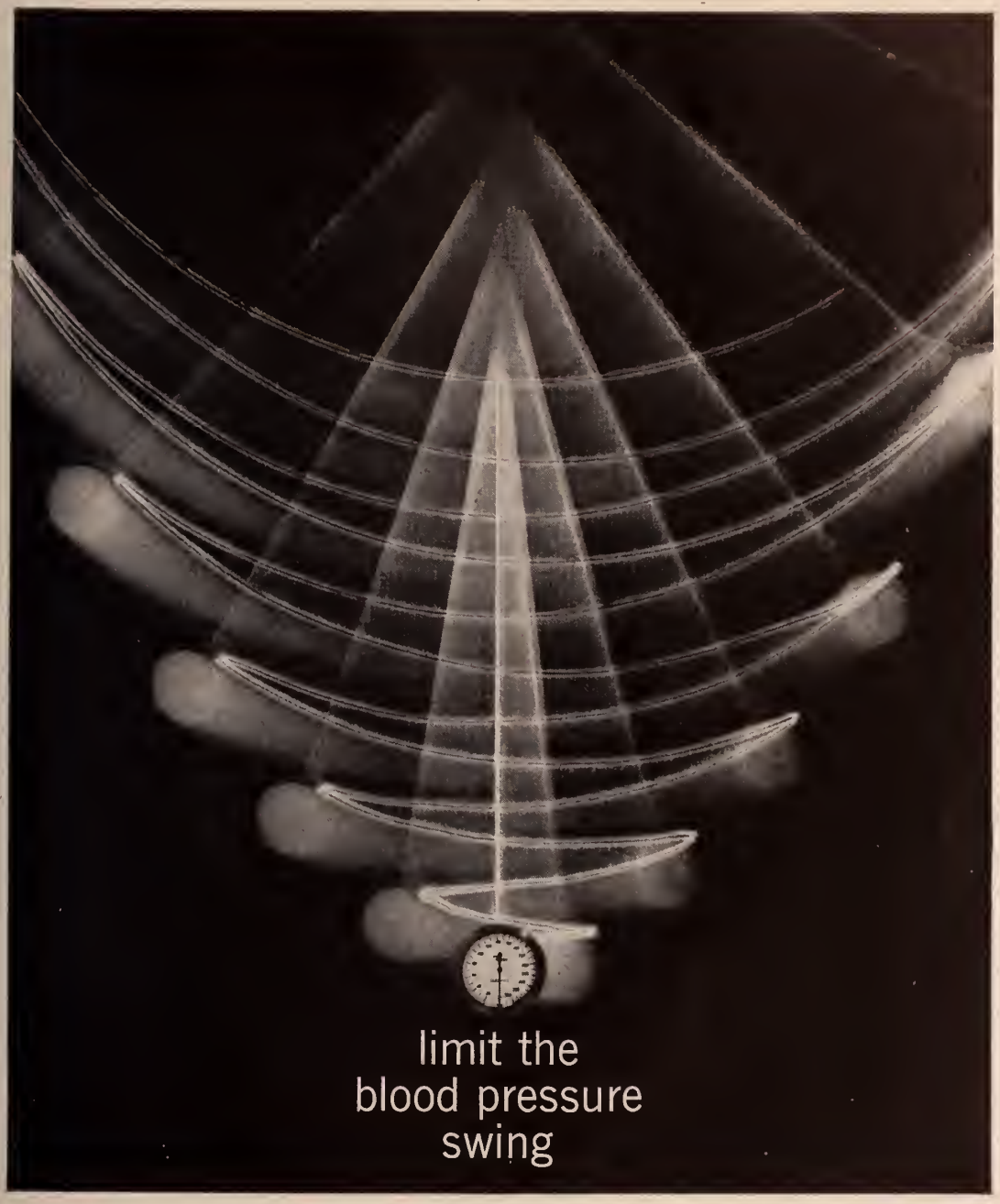
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(dehydrocholic acid with belladonna, AMES)

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Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing. Rautrax-N combines Raudixin, the cornerstone of antihypertensive therapy, with Naturetin, the new, safer diuretic-antihypertensive agent. The complementary action of the components permits a lower dose of each thus reducing the incidence of side effects. The result: Maximum effectiveness, minimal dosage, enhanced safety. Rautrax-N also contains potassium chloride — for added protection against possible potassium depletion during maintenance therapy.

Supply: Rautrax-N — capsule-shaped tablets — 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. Rautrax-N Modified — capsule-shaped tablets — 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride. For complete information write Squibb, 745 Fifth Avenue, New York 22, N. Y.

new Rautrax-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

Squibb Quality—The Priceless Ingredient

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RAUDIXIN,® RAUTRAX,® AND NATURETIN® ARE SQUIBB TRADEMARKS.

FOR THE ANXIETY TENSION PATIENT WHO IS ABOUT TO





Effective Anticholinergic-Antitensive

Relaxes the Spastic G. I. Tract

SED-TENS TY-MED*

A unique timed-release principle incorporating the delayed acting therapeutic ingredients in an inert tablet matrix.

The release of medication is an erosive mechanical process independent of chemical media, therefore, not effected by gastro-intestinal environment.

DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital . . . . . 50 mg.
Homatropine Methylbromide 7.5 mg.

*LEMMON brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

LEMMON PHARMACAL CO

Sellersville, Pa.



What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus — watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

© Florida Citrus Commission, Lakeland, Florida



in sinusitis, colds and upper respiratory disorders

NEW

DIMETAPP® Extentabs®

let your patients breathe easier!



In sinusitis, colds and other upper respiratory and allergic disorders, new DIMETAPP Extentabs offer more useful decongestant therapy. Stuffiness, drip and other annoying symptoms of congestion are effectively relieved with minimum side effects.

UNSURPASSED RELIEF OF NASAL CONGESTION DIMETAPP Extentabs contain an unexcelled antihistamine, Dimetane, which has produced good to excellent results in thousands of cases of allergic respiratory disorders.* In DIMETAPP Extentabs, the action of Dimetane with two outstanding decongestants—phenylephrine and phenylpropanolamine—promptly dries secretions and reduces edema and congestion in the nose, the sinuses, and the upper respiratory tract.

CLEAR BREATHING FOR 12 HOURS ON 1 TABLET Long-acting DIMETAPP Extentabs offer up to 12-hour relief on just one tablet. Easier to use than nose drops or sprays, DIMETAPP reaches into areas topical decongestants can't touch—without rebound congestion.

EXCEPTIONAL FREEDOM FROM SIDE EFFECTS With DIMETAPP Extentabs, there's little problem of either drowsiness or overstimulation. The antihistamine component, Dimetane, offers a high percentage of effective relief with only drowsiness as a possible infrequent side effect.* Small, fully efficient dosages of decongestants minimize the danger of overstimulation.

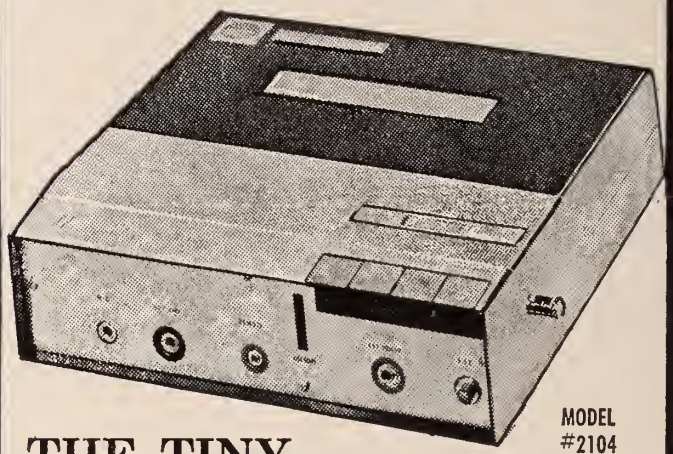
DIMETAPP Extentabs contain Dimetane® (parabromdylamine [brompheniramine] maleate) 12 mg., phenylephrine HCl 15 mg., and phenylpropanolamine HCl 15 mg. Dependable Extentabs construction assures relief of symptoms for up to 12 hours with 1 tablet.

Dosage: Adults—1 Extentab q. 8-12 hours. Children over 6—1 Extentab q. 12 hours. Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension, and to those sensitive to antihistamines. See package insert for further details. **Supplied:** bottles of 100 and 500.

*Full bibliography on Dimetane available on request.

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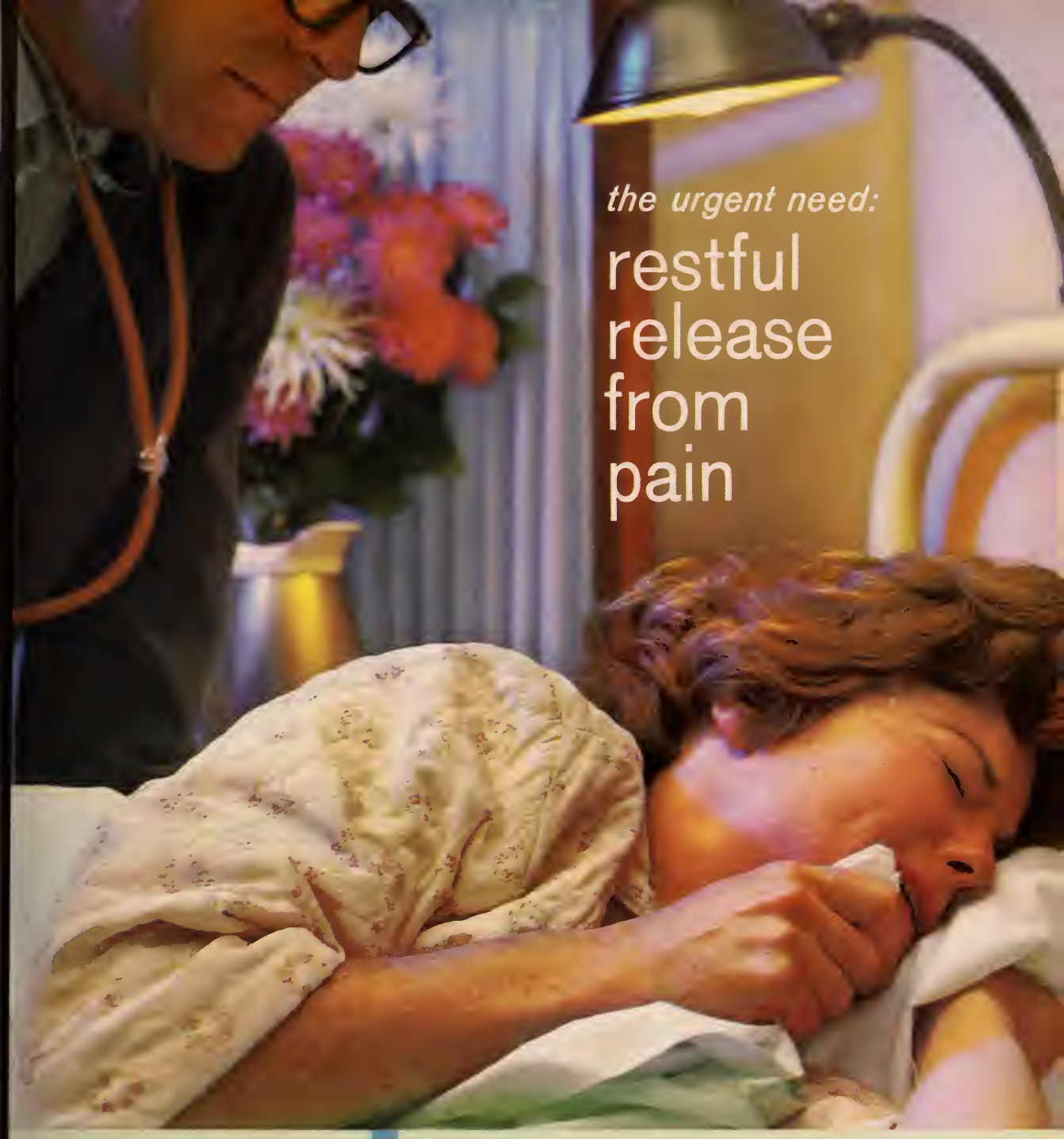
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AHR

PHENAPHEN
(Basic formula)

In each capsule: Phenacetin (3 gr.) 194.0 mg.; acetylsalicylic acid (2½ gr.) 162.0 mg.; hyoscyamine sulfate 0.031 mg.; and phenobarbital (¼ gr.) 16.2 mg.

AHR

PHENAPHEN No. 2

PHENAPHEN with Codeine ..... ¼ gr.

AHR AHR

PHENAPHEN No. 3

PHENAPHEN with Codeine ..... ½ gr.

AHR

PHENAPHEN No. 4

PHENAPHEN with Codeine ..... 1 gr.

SUPPLY: Bottles of 100 and 500 capsules.

sedative-enhanced analgesia

To each "according to his need" — maximum safe analgesia through time-and-pain-tested synergistic formulations, in four strengths for individualized prescription.

PHENAPHEN®

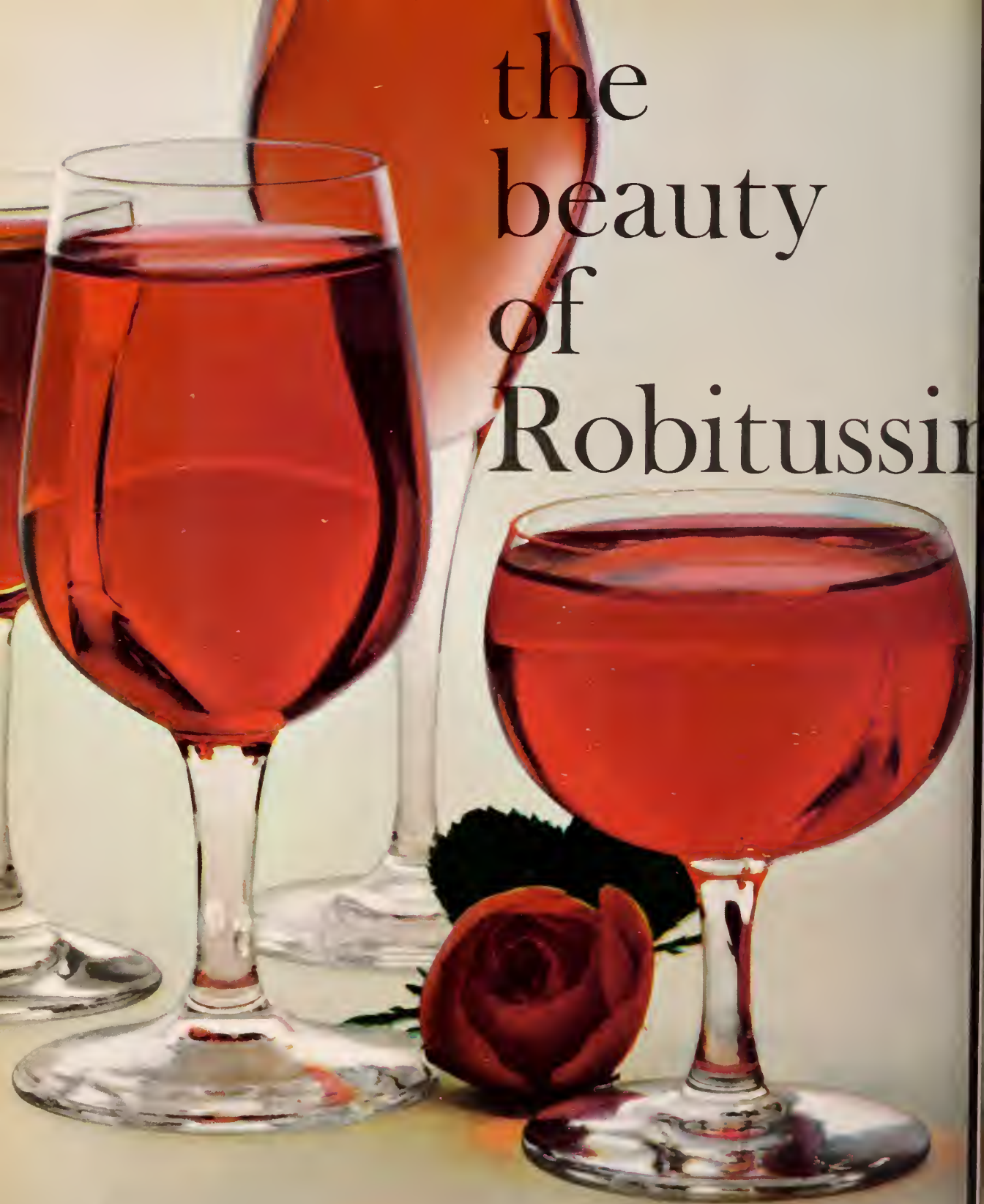
Robins

PHENAPHEN® WITH CODEINE

¼ gr. ½ gr. 1 gr.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence



The real beauty of Robitussin is seen in the relief it brings to cough. By increasing the tracheal flow of respiratory tract fluid, Robitussin's glyceryl guaiacolate turns useless cough into productive cough. Efficient yet gentle, Robitussin helps the cough rid itself of the very irritants that cause it. And in more than a decade of use it has proved unquestionably safe, as well as consistently acceptable, to patients of all ages. Robitussin® is glyceryl guaiacolate, 100 mg. per 5 cc. dose; Robitussin® A-C adds prophenpyridamine maleate 7.5 mg., and codeine phosphate 10.0 mg. per 5 cc. dose (exempt narcotic).

A. H. Robins Company, Inc., Richmond 20, Virginia

for balanced diuresis in:

cardiac edema • congestive heart failure • premenstrual tension • edema of pregnancy toxemia of pregnancy • obesity

often invaluable in: epilepsy Ménière's syndrome • glaucoma

Ample diuresis for the commonly seen edematous patient...gentle... without excessive distortion of electrolyte or normal water patterns ...without effect on blood pressure.

Scored tablets of 250 mg. Ampuls of 500 mg. for parenteral use.



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LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle



chronic leg ulcer?

"many patients who had ulcers  from one to eight years obtained complete healing in six to ten weeks."[1]



CHLORESIUM®

ointment

CHLORESIUM Ointment has long been recognized as a medication of choice for local treatment of chronic wounds and ulcerations.[1,2] This time-tested agent is noted for its ability to promote healthy granulation, encourage normal epithelization, relieve pain and inflammation, and deodorize malodorous lesions. Furthermore, a complete lack of irritating or sensitizing properties makes CHLORESIUM ideal for patient-use at home.

CHLORESIUM Ointment—0.5% water-soluble chlorophyll derivatives in a hydrophilic ointment base, in 1-oz. and 4-oz. tubes.

CHLORESIUM Solution—0.2% water-soluble chlorophyll derivatives in isotonic saline solution, in 2-oz. and 8-oz. bottles.

(1) Boehme, E. J.: Lahey Clin. Bull. **4**:242, 1946. (2) Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Samples and literature available on request

Rystan Mount Vernon, N.Y.

34763

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



Garden City, N. Y.



Lincolnwood, Ill.



Skokie, Ill.



Denver, Colo.



Denver, Colo.



No. Massapequa, L. I., N. Y.



Roselle, Ill.



Seaford, N. Y.



Hartford, Conn.



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Norwich, Vt.

DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

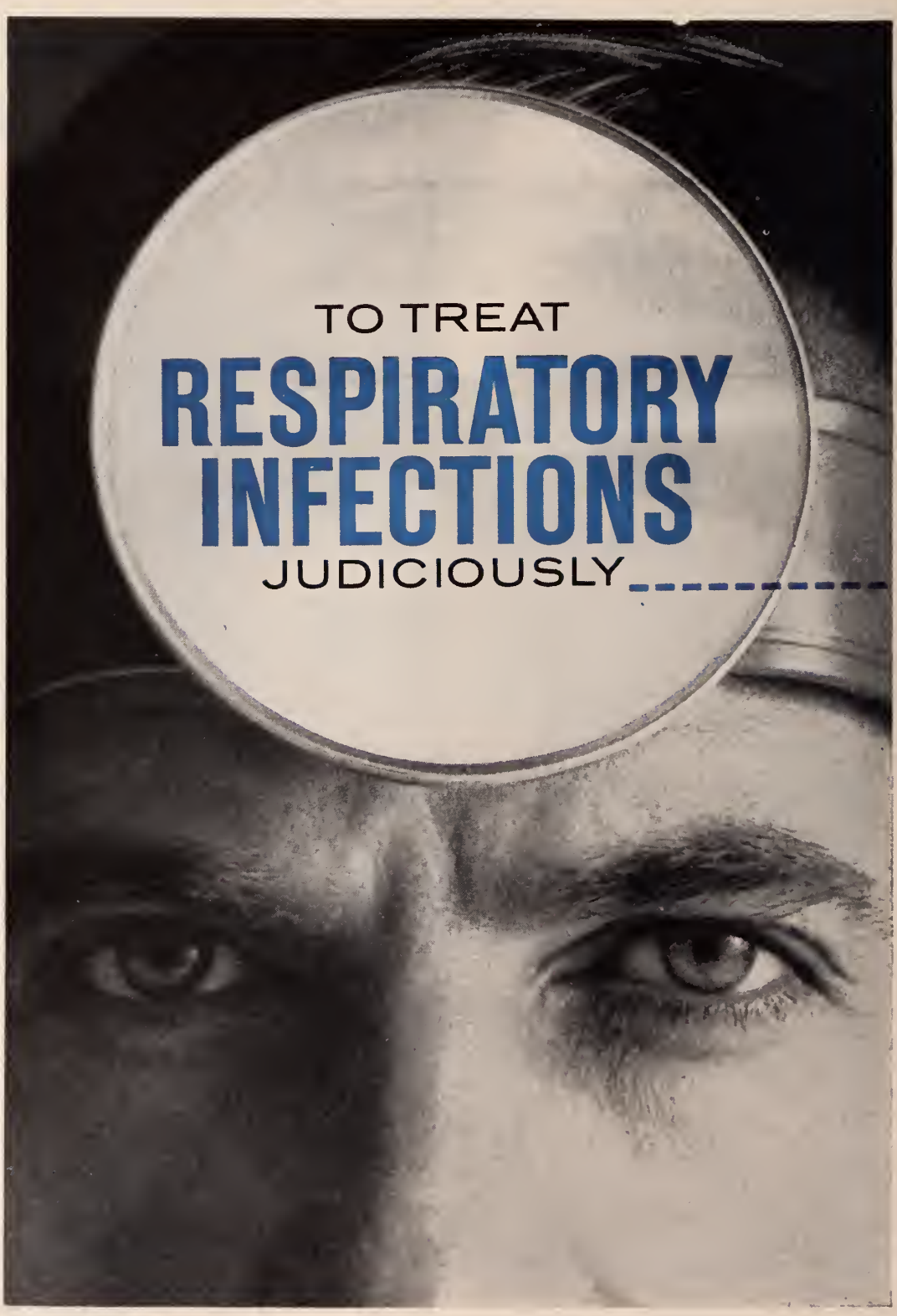
Complete information on administration and dosage is supplied in the package insert

Supply:
Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

SQUIBB *Squibb Quality—The Priceless Ingredient*

"DELALUTIN" ® IS A SQUIBB TRADEMARK


TO TREAT
RESPIRATORY
INFECTIONS
JUDICIOUSLY

When it's penicillin-susceptible
and the patient is not allergic
Use an orally maximal penicillin

MAXIPEN®

potassium phenethicillin



Consistent dependable therapeutic response through maximal absorption, maximal serum concentration and longer duration of inhibitory antibiotic levels for less susceptible organisms.

Available as Maxipen Tablets, 125 mg. and 250 mg.; Maxipen for Oral Solution, 125 mg. per 5 cc. of reconstituted liquid.

Literature on request

— — — —

In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

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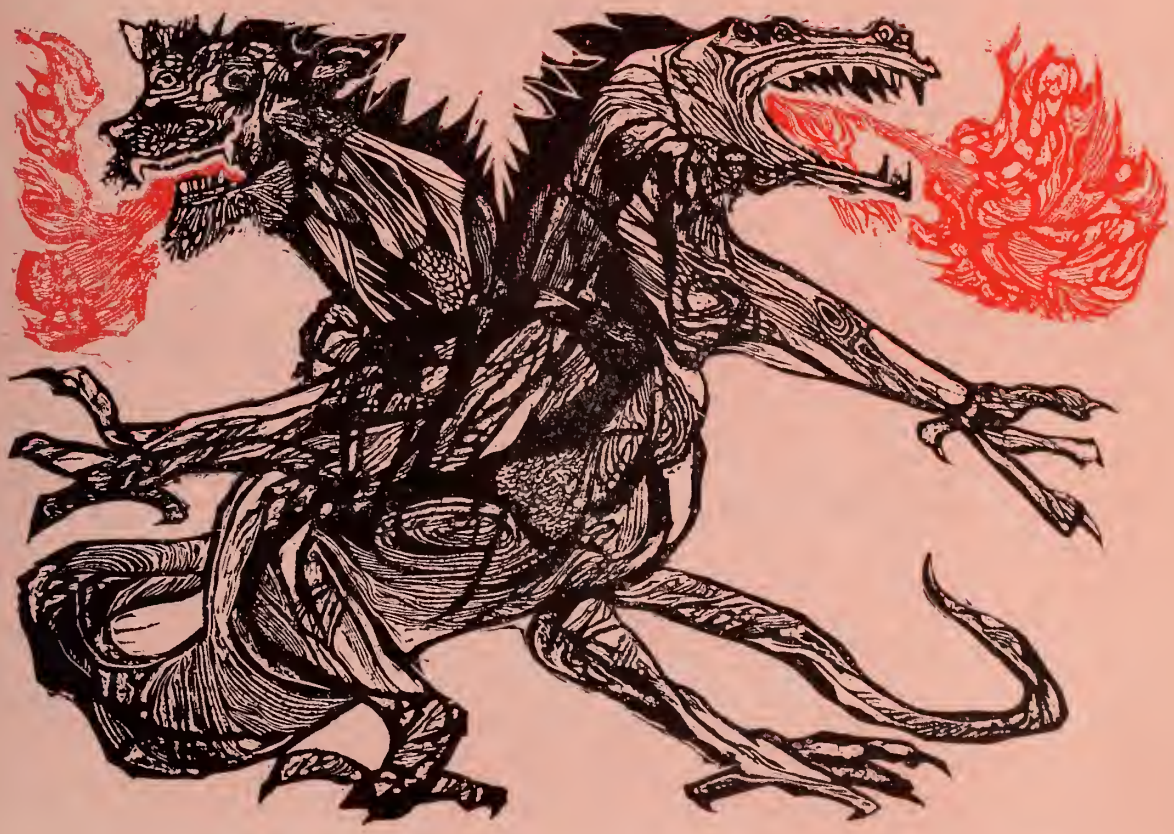
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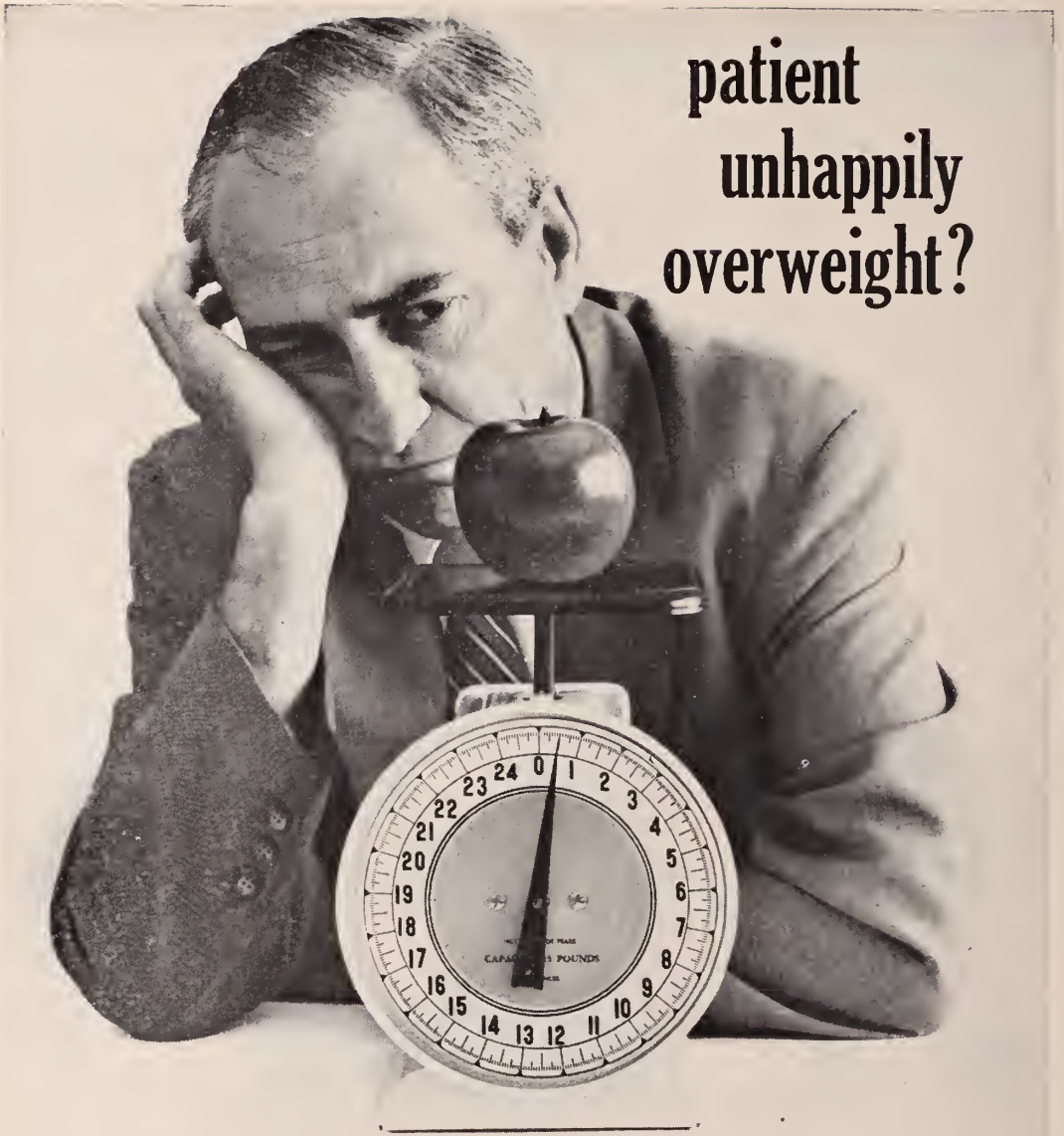
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[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

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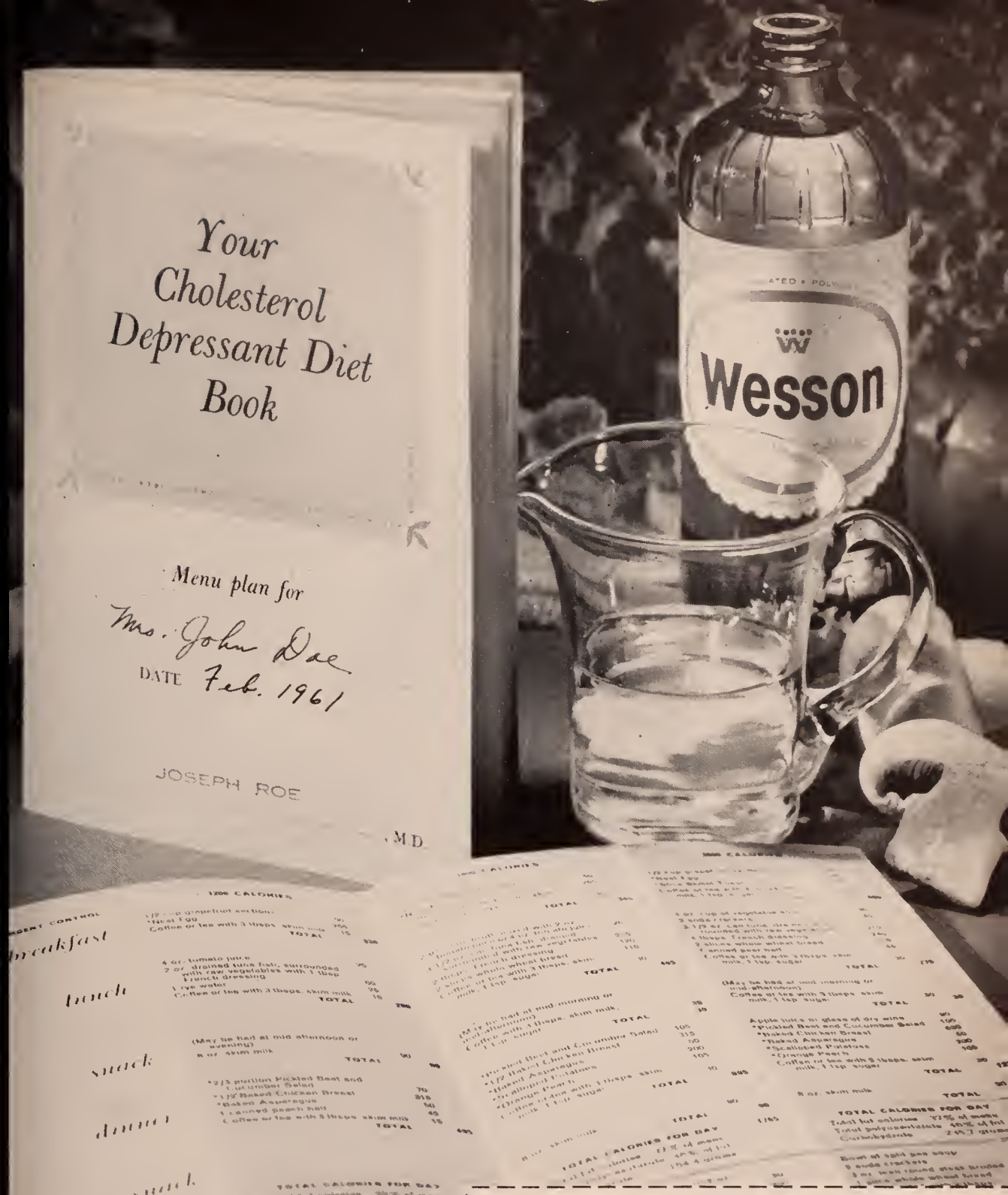
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*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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Editorials • • •

Medical Aspects of Automobile Accident Prevention

The physician's duty to help his patient sometimes conflicts with a civic duty to impose a restriction or disability on a patient. For example, a patient with a highly contagious disease might want to continue working, but common sense demands that he be isolated. A duty to respect a patient's confidence might clash with a duty to report a bullet wound or a contagious disease. In the field of automobile licensure, a number of conscience-trying dilemmas may present themselves. Should a patient subject to unpredictable periods of coma be permitted to drive—whether the black-outs are due to epilepsy, coronary disease, alcoholism or diabetes? Obviously not. But then is it the duty of the treating physician to notify the Motor Vehicle Division?

One answer to this dilemma has been the hope of developing firm medical criteria to be applied at the time of first application for a license; and thereafter at intervals. In a conference held under the auspices of New York University's Center for Safety Education, a staff of medical and traffic experts held an all-day workshop in cooperation with the New York Academy of Medicine.

Among the conclusions and recommendations arrived at by the conference participants were the following:

Driver attitudes and personality characteristics have a major role in traffic accidents. Research in this area must be intensified.

Qualifying medical examinations should be mandatory prior to the first issuance of a license. A qualifying examination should be given prior to each renewal of the license.

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Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
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Whole Number of Issues 678

Vol. 58, No. 2 February, 1961

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Fourteen cardiovascular conditions, ranging from severe diminished cardiac reserve to fixed hypertension above 180/100, were specified as disqualifying for motor vehicle operation.

Those subject to epilepsy and other conditions which bring about transient lapse of consciousness or motor control should be periodically examined to determine their fitness to wrive. The motor vehicle director should have a panel of specialists to advise in this evaluation.

Minimum visual requirements for private car operation should be a correctible visual acuity to 20/40 Snellen in the better eye and a form field of 70 in the horizontal meridian in each eye, or 140 in one eye; vision to be reexamined every three years.

Certain conditions of the head and neck, diseases of the thoracic cage, limited functions of arms and legs, and certain conditions of the spine should be considered as precluding the safe operation of motor vehicles.

If alcohol is detected by chemical tests when a driver is involved in an accident, or if he refuses to take a test, a mark should be placed on his driving license. In case of a second accident, if alcohol is again detected, or if he again refuses to take a test, the driver's license should be suspended while the driver's drinking habits are investigated by a clinician appointed by the authorities.

One may, of course, disagree with some of these specific recommendations; or prefer to add others. The point would seem to be, however, that physicians have an important role to play in evaluating medical fitness of drivers. It is not a pleasant duty—not one that any of us would solicit. But it is only proper that the motor vehicle authorities turn to the medical profession for guidance in this area.

Breakfast and the Morning Snack

The mid-morning break has become part of the American tradition and is one of the fringe benefits often claimed by labor. The usual justification is that this increases productivity; and that in return for a fifteen-minute break in the morning routine, the employer can look for heightened morale as well as a better yield of work.

There seems to be some evidence that this is a basically sound concept and that when employees stop work about 10:00 or 10:30 in the morning, they do return to their desks with renewed vigor. However, some people use the mid-morning break as a substitute for breakfast. Or to put it another way, they are getting up later and skipping breakfast. They justify this on the grounds that, after they are at the desk for an hour or so, they will then have coffee and doughnuts or pastry.

The question reduces itself to determining which is better: a normal breakfast or a mid-morning snack? Ordinarily there are more calories in a morning breakfast. Sometimes the breakfast is taken in great haste, whereas the mid-morning break (being on company time) is likely to be in a more relaxed atmosphere. The only experimental study of this appeared in the August, 1960, issue of the Journal of the American Dietetic Association. It was conducted by Doctors Tuttle and Herbert. Productivity was determined by having the subjects do work against a bicycle ergometer. This study (for which there was no lack of volunteers) indicated that the subjects did more work when they had an adequate breakfast *without* a mid-morning snack than they did when they had no breakfast but did take a typical mid-morning break. In so far as this is a valid study, it appears that breakfast triumphs over the coffee break. The study is perhaps only slightly diluted by the fact that it was financed by the Cereal Institute which, presumably, has an interest in promoting big breakfasts.

The physician is looked on as a family adviser on all health problems. It is good for him to know, if asked, that the only scientific experiment on the subject suggests that if one must choose between an adequate breakfast or a mid-morning break, the breakfast wins hands down.

RALPH H. VAN METER, M.D.

Moorestown

Uses and Abuses of Intravenous Oxytocin*

We have had a half-century of experience with oxytocin in obstetrics. Dr. Van Meter shows the advantages of intravenous over hypodermic injection, and highlights the fact that responsibility for decision belongs to the attending physician.

DURING the past decade, obstetricians have made wide use of preparations of the posterior pituitary lobe. It is now 51 years since the oxytocic activity of extract of the posterior pituitary lobe was reported by Dale,[1] who observed the vigorous contractions produced in the virginal guinea pig uterus. Hofbauer[2] made his first report on the use of the extract of the posterior pituitary in labor in 1911. He reported on the efficacy of the drug in uterine inertia, overcoming bladder atony and induction of labor. During the next two years, more than one hundred papers appeared confirming Hofbauer's experience.[3]

Hofbauer's second report[4] seven years later outlined the basic indications and procedures required to avoid indiscriminate use of the drug. He stated that a thorough examination is indispensable to rule out cephalo-pelvic disproportion and abnormal presentation.

Over the years use of the preparation was the subject of much discussion both formally and informally. In 1946 Reid[5] wrote that "posterior pituitary extract can be safely administered in labor without undue harm to mother or baby." In 1948 Theobald[6] advocated oxytocic principle in small doses intravenously.

The purpose of this discussion is to review again the indications for intravenous oxytocin, to emphasize its advantages and disadvantages, and to point out the abuses to which this preparation has been subjected either in ignorance or with disregard for safety. This will be interpreted in light of the accumulation of nearly fifty years of clinical observations by numerous investigators and in view of present day pharmacology, anesthesiology and practice of obstetrics.

In a recent paper concerning the elective induction of labor, Schaeffer[7] states:

"One of the functions of the obstetrician is to make the delivery as safe, as simple, and as comfortable as possible. To accomplish this, certain artificial procedures, such as 'prophylactic forceps,' episiotomy, analgesia and anesthesia have been added to our armamentarium. Although these

*Read in Atlantic City before the Obstetrical Section at the Annual Meeting of The Medical Society of New Jersey, May 17, 1960.

1. Dale, H. H.: Biochemical Journal, 4:427 (1909).
2. Hofbauer, J.: Zentralb f. Gynäk, 35:137 (1911).
3. Hofbauer, J.: American Journal Obst. & Gynec., 69:822 (1955).
4. Hofbauer, J.: Monatschr. f. Geburtsh u. Gynäk., 48:325 (1918).
5. Reid, Duncan E.: American Journal Obst. & Gynec., 52:731 (1946).
6. Theobald, J. W.: British Medical Journal, 2:123 (1948).
7. Schaeffer, G.: Obst. & Gynec. 15:465 (1960).

procedures may occasionally be associated with some intrinsic dangers, sound judgment and skill acquired from experience have reduced these hazards so that the advantages outweigh the disadvantages; as a result they have become generally acceptable.

"A recent supplement to the practice of obstetrics has been the elective induction of labor. If it can be demonstrated that this, too, can be performed without increasing the hazards to either mother or infant, it may be accepted without censure or skepticism. The question is whether it is better to reduce the practice of obstetrics to mediocrity by avoiding any new procedures than to train ourselves to do it safely and well."

Research [8] has isolated the active oxytocic factor in the extract of the posterior pituitary lobe and this is available under the commercial trade-name of Pitocin.® The U.S.P. designation is oxytocin. In addition to the biological source, a synthetic preparation, trade-named Syntocinon® is now available. With minor differences the two preparations have nearly the same pharmacodynamic action on the uterine musculature. For convenience in this discussion the generic term oxytocin will be used for both preparations.

MANY obstetricians have used oxytocin in multiple subcutaneous injections. The efficiency of the drug was modified by the rate of its absorption from the site of injection. Tetanic contractions occasionally resulted when absorption was very rapid or when inadvertent and unrecognized intravenous injection occurred. In other instances, very slow absorption produced little effect. Delayed absorption at times produced a cumulative effect as the drug was absorbed during an intermittent course in injections. Once the injection was given the limitations due to rate of absorption in some instances increased the risk to the mother and child, since it denied control of the myometrium to the obstetrician.

Intravenous administration of the preparation eliminates the problem of absorption. The agent administered in the vein reaches the uterus in a matter of seconds and (according to Page [9]) one-half of the oxytocin is inactivated in the first ninety seconds. All of the oxytocin is de-activated in six to eight minutes. As a result, any undesirable action can be limited by time and rate of administration. Each patient must be evaluated carefully and the decision to use the stimulating agent be evaluated. Lubin [10] gives the following list in which oxytocin finds its greatest application:

1. Stimulation of labor.
2. Induction of labor.
3. Cephalo-pelvic disproportion relative.
4. Breech presentation with average size fetus.
5. Parity of not over four.
6. Age of patient is not a limiting factor.
7. Twins with ruptured membranes.
8. Large fetus with adequate pelvis.
9. Fetal condition poor.
10. Fetal death.
11. Premature separation of the placenta.
12. Marginal placenta previa.
13. Post-partum hemorrhage.
14. Septic incomplete abortion.

The list of contra-indications is shorter but failure to recognize or to consider these factors is to court disaster. A basic adage is, "If doubtful of the indication, do not use."

The list of contra-indications are:

1. Drug sensitivity.
2. Contracted pelvis or definite disproportion.
3. Large breech.
4. High parity with large fetus.
5. Twins with over-distention of the uterus and intact membranes.
6. Previous sections, hysterotomy or myomectomy.
7. Abnormal presentation: brown, shoulder, transverse lie, *et cetera*.
8. Maternal exhaustion (until corrected).
9. Poor physical condition of the patient.

A study of these two lists highlights the enormous importance of the clinical judgment of the obstetrician. The decision is the responsibility of the attending physician and is not to be delegated to the nursing, intern or resident staff.

The patient in active effective labor does not need stimulation. Under these conditions, oxytocin represents an abuse, as would the use of oxytocin in a patient with a disproportion in active labor and an unengaged head. On the other hand a patient in desultory labor can often be stimulated into effective progress

8. Douglas, E. *et al.*: Obst. & Gynec., 12:581 (1958).

9. Page, Ernest W.: Western Journal of Surgery, 62:125 (1954).

10. Lubin, S. *et al.*: American Journal Obst. & Gynec., 64:248 (1952).

with the judicious use of intravenous oxytocin.

Here are the basic factors to be considered for safe administration of this agent.

1. The attendant must be present.
2. The infusion must be started slowly. A dilution of one unit of oxytocin to 100 milliliters of 5 per cent glucose is the most frequently used concentration. Preferably the oxytocin should be added to the flask after the infusion is started. The occasional patient may respond to a rate as low as four to six drops per minute.
3. The patient must be watched carefully, even if the rate and response is such that the uterine contractions are that of active labor, with adequate relaxation. The patient must be watched, since any movement of the patient which pulls the tubing may disturb the adjustment and increase the rate of flow. The objective is to induce or stimulate effective uterine contractions. This can be determined by observation of the frequency and duration of the contraction, and by palpation of the fundus during contractions.
4. Fetal heart tones must be checked frequently.
5. With untoward reaction on the part of the mother or the fetus the infusion should be stopped or the rate reduced.

If prompt induction is in order, all efforts and aids should be brought to bear to establish labor. This would be true for the toxic patient who is under reasonable control and for the patient with Rh incompatibility where further delay increases the risk. The same factors for indication hold here: the vertex must be engaged and there must be no disproportion. This is the time for thorough preparation. The membranes should be ruptured and the infusion started. These cases represent what may be termed mandatory indications. At least the patient's and infant's safety depend on early termination of the pregnancy. An attempt at induction is usually in order. If it is unsuccessful, the patient can be delivered by section.

A patient in active labor, particularly a parous patient who shows signs of some degree of separation, may offer the opportunity to achieve quick delivery if the membranes are ruptured and oxytocic infusion is started. In selected cases the time required for vaginal delivery may be shorter than the time required for section.

Numerous papers have appeared concerning the use of intravenous oxytocin for elective induction of labor. Definite advantages have been listed including adequate preparation of the patient, careful observation during labor, the presence of the obstetrician, and the home situation of the patient.[11] There is a strong feeling that the procedure does not include the nulliparous patient. Certainly the advantage of having labor induced in a patient who has a history of very short labors where travel to the hospital may be a definite factor and where technic is compromised is obvious. However, the patient must be selected on the following:

1. She must be at or near term.
2. A history of previous normal labor and delivery.
3. There must be no evidence of disproportion.
4. Vertex presentation.
5. The patient must be willing to be induced.
6. Suitable pelvic findings as determined by pelvic examination—
   a. The cervix must be "ripe," soft, effaced, 3 centimeters dilated.
   b. Presenting part should be at station minus 1 or lower.

Judicious use of intravenous oxytocin will produce effective uterine contractions which will increase in duration and frequency. The rate of administration is regulated according to the response.

Anesthesia must be selected accordingly. Some anesthesiologists hesitate to use cyclopropane to anesthetize a patient receiving an oxytocin infusion due to danger of ventricular fibrillation. This is more true of the biologic product. The synthetic agent is supposed to have a less sensitizing effect on the heart.

Intravenous oxytocin infusion can be used effectively with regional anesthesia particularly saddle block and caudal. The loss or impairment of voluntary muscular activity can be compensated by the infusion. Rutherford[12] found that maternal and fetal mortality between his series and a control group were parallel. The number of posterior or transverse arrests were less than in the control group. Accordingly there is higher incidence of spontaneous deliveries. This is one aspect

11. Bishop, E. H.: Surgical Clinics, 85:1545 (1954).
12. Rutherford, R. N. *et al.*: Western Journal of Surgery, 61:285 (1960).

of intravenous oxytocin which has received comparatively little recognition.

SUMMARY

THIS report reviews briefly the history of the development of oxytocin. The advantages in the control and response to the intravenous route as compared to the subcutaneous injection have been stressed.

The physician is responsible for the evaluation of indications and contra-indications, for the proper selection of the patient, for induction with intravenous oxytocin and her supervision until delivered. This is true whether the indication is elective or based on medical indications.

Certain advantages of intravenous oxytocin with regional anesthesia have been pointed out.

Oxytocin is a powerful agent, which, if used carefully, has a place in the armamentarium of the obstetrician. But there is no place for casual regard or indifference in its use. Use it with proper respect or do not use it at all.

244 West Main Street

Alcoholism in Industry

Alcoholics may be spared some of the responsibility for meeting their own problems according to currently fashionable plans for helping alcoholics in business and industry. Writing in *Today's Health* (December 1960) Howard Earle says that business firms have awakened to the staggering cost and innumerable problems related to the harboring of "hidden" alcoholics, or firing them without attempting rehabilitation.

Many companies have established alcoholism programs to seek out the problem drinkers in their ranks and offer them treatment.

Under this new "soft approach," as Mr. Earle calls it, alcoholism will come under direct attack in the office and in the factory where the early stages of the problem drinker may be detected through close observation of his behavior.

There are various estimates of the number of alcoholics in industry. It is commonly accepted that there are more than three million with one estimate as high as five million.

Alcoholism costs industry more than 500 million dollars annually in hospitalization and known expenses and an estimated 10 billion dollars more each year in indirect costs resulting from absenteeism, inefficiency, and accidents.

It takes 10 to 15 years of steady drinking for a person to become addicted to alcohol. Many efficient workers do not exhibit deterioration for a long time. Fellow workers usually cover up for the drinker and rarely tip off supervisors.

The companies concerned think that alcoholism is a treatable disease. Recovery is possible for all alcoholics if cooperation of the patient is obtained.

"Various methods are used by industry's alcoholism programs to treat alcoholics," the article said. "Some use counselling by trained counsellors. Some rely upon their medical departments. Others maintain separate clinics like Chicago's Portal House where psychiatrists, and psychologists are available.

"Some have found success with Alcoholics Anonymous . . .

"Excellent results have been achieved, also, in merely interviewing the involved individuals and referring them to community resources, such as family relations agencies, welfare and health departments, and medical societies."

The program at Consolidated Edison shows 85 per cent of the problem drinkers discovered are willing to go to a consultation clinic set up by the company. Allis-Chalmers reduced its discharges of alcoholics from 95 to 8 per cent through its program for alcoholics at a savings of $80,000 a year.

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Summit

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Union

Stupor from Dextroamphetamine-Amobarbital and Monoamine Oxidase Inhibitor, Phenelzine

A 43-year old woman with liver impairment from previous alcoholism went into stupor after having taken phenelzine in therapeutic doses for some time and an unknown quantity of dextroamphetamine-amobarbital. There was probably accumulation of amphetamine and barbiturate in the blood stream.

The following case of stupor in a 43-year old woman is presented because of its unusual and puzzling features. It resulted from a combination of drugs used for their stimulating effects. We hope that others who encounter similar syndromes may be able to fill in more details and add to our basic knowledge.

This is a 43-year old woman who had been known to indulge in alcohol sporadically in an excessive manner, especially when her husband was out of town for a few days. During these times, she would become stuporous, sustaining bruises, neglecting both herself and the care of a 14-year old son. These episodes occurred every few months. She would offer various reasons for indulgence; *e.g.*: she was "scared" when her husband was away; her husband "checks up" on her too much; this makes her want to "get even;" she can't drink very much because she gets sick, and her husband, when home, talks her into drinking more than is good for her. She is an insecure, unsure person dependent upon her husband, yet resenting her dependence and trying to act self-assured without succeeding. Although fearful of becoming a chronic alcoholic, she was unwilling to take the necessary steps to change. Disulfiram* medication was recommended but she avoided having the preliminary liver function tests done. Apparently, she did not want to take Antabuse.®

When she entered Overlook Hospital she was in a stuporous state. She had been behaving "peculiarly," manifesting incoordination in her movements, thrashing about the bed, gesticulating bizarrely, grimacing and "jerking" aimlessly. She responded to simple questions in a stuporous way, sometimes relevantly, sometimes irrelevantly or unintelligibly. She complained of severe thirst. She denied consuming any alcohol recently; none could be detected by odor, and there were no empty bottles at home. She had complained of a

*Disulfiram is tradenamed by Ayerst as Antabuse®.

cough, fever, cold, and cold sweat prior to becoming restless and stuporous. She had no fever on admission. Pupils were equal, regular, active bilaterally to light. Cranial nerves were normal as far as could be tested. Deep tendon reflexes were hyperactive but no Babinski response was obtained. She quieted with 50 milligrams of chlorpromazine intramuscularly and fell asleep. Six hours later, she could be aroused to drink and obeyed simple commands, but she could not concentrate enough to tell what had happened. She showed irregular "jerky" movements of extremities with disjointed twitching of facial muscles. Pupils were equal and reacted to light. Eyeball movements were not coordinated with each other when not fixing on an object. She withdrew her feet on testing for Babinski reflex. Blood pressure was 98/70. There was no alcoholic or other odor.

Course: In four days, she was fully recovered and was as alert as ever. At this time, she stated she believed she had taken phenelzine dihydrogen sulfate (Nardil®) as directed; namely, 15 milligrams three times a day. She had recently reordered dextroamphetamine-amobarbital combination (Dexamyl Spansules®) from her pharmacy. Undoubtedly, she exceeded the prescribed dose of one Spansule in the morning. How many were actually consumed is conjectural. She was sure she had done no drinking and had taken no other medication. Physical examination in the hospital did not show any liver enlargement or tenderness.

Laboratory Findings: On admission, urine analysis showed no glucose, one plus albumen with strongly positive acetone. Blood bilirubin was 1.28 milligrams total. Direct .48 milligram. Indirect .80 milligram. *Cephalin Flocculation*: 24 hours: 2 plus; 48 hours: 2 plus. *Sugar*: 109 milligrams. *Urea Nitrogen*: 27.5 milligrams.

Two days later the blood *sugar* was 93 milligrams. *Urea nitrogen* 16 milligrams. *Hemoglobin* 11.4 Grams. Hematocrit 37 per cent. White blood cells 12,500.

Further Developments: On recovery from stupor, it was recommended that she enter a psychiatric hospital. She entered one a month later. On admission there, she was found to have liver enlargement of three fingers below the costal margin. This was again noted on examination three weeks later. No tests of liver function were made during her stay at that hospital. She did have a drug reaction characterized by erythematous rash, fever, sore throat, and enlarged cervical glands. This was felt to be a reaction to glutethimide (Doriden®). It was similar to the fever and sore throat from which she suffered prior to admission to Overlook Hospital.

Here was an unusual situation: two drugs whose ordinary actions were thought to be "stimulative" resulted in a severe stupor bordering on coma. We wrote to the Psychopharmacology Service Center of the National Institute of Mental Health in Bethesda, Maryland. This was answered by Reese T. Jones, M.D. He could only find one case [1] with any similarity. Here, the patient ingested two or more Grams of iproniazid. This patient had tachycardia, fall in blood pressure, diaphoresis, and unresponsive pupils besides semi-stupor and insomnia. Dr. Jones stated that monoamine oxidase inhibitors prolong barbiturate induced sleeping time in animals presumably by blocking the detoxifying function of the liver. Plas *et al.*,[2] have reported this condition and it has been used as a screening test for the activity of newly-developed monoamine oxidase inhibitors on the liver. The initial information supplied on nialamide (Niamid®),[3] another amine oxidase inhibitor, indicated that the antidepressant effect had no bearing on the liver effect.

CONCLUSIONS

THIS patient went into stupor because of several factors. Liver impairment probably ex-

1. Plas, G. A., Evans, E. A. and Hines, C. H.: Journal of Pharmacology and Exper. Therap., 123:224 (1958).

2. Fouts, J. R. and Brodie, B. B.: Journal of Pharmacology and Exper. Therap., 116:480 (1956).

3. Goldin, A. *et al.*: Science, 121:364 (1955).

isted from prior alcoholism. Liver function was further interfered with by a monoamine oxidase inhibitor, phenelzine dihydrogen sulfate. The failure of the usual process of detoxification in the liver by conjugation must have resulted in an accumulation of large amounts of barbiturate in the blood stream from the dextroamphetamine-amobarbital combination (containing 15 milligrams of dextroamphetamine and 97 of amobarbital per capsule). The presence of large amounts of circulating dextroamphetamine as well, must have caused the "jerky," incoordinated movements and restlessness in this patient. If we had pursued this thought at the time, we might have taken blood for barbiturate determination. This would have either confirmed or refuted our conjectures.

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Journal of Surgical Research

This spring will see the launching of a journal devoted to research in surgery. Edited by Charles Child of the University of Michigan, its board includes Henry Bahnson, Robert Gross, Jonathan Rhoads, and Owen Wangensteen. Subscription is $10 a year. Remittances are sent to W. B. Saunders, Washington Square, Philadelphia 5, Pa. Manuscripts go to Dr. Charles G. Child at the Department of Surgery, Medical School, Ann Arbor, Michigan. Manuscripts should relate to research which "illuminates the nature of surgical disease, suggests new technics of study, or proposes new methods for management or recognition" as well as material on experimental work in surgery generally.

Compulsory Retirement

Compulsory retirement of employees at age 65 is on the decline, according to an editorial in the December 31, 1960, Journal of the American Medical Association. "In recent years . . . some companies, as well as the public, seem to favor a more liberal retirement policy. One reason for the change is that more employees are in good health at 65 today than a generation ago and continue to use their experience and skill to the benefit of their employers.

"The American Medical Association asked labor and industry to re-evaluate their support of arbitrary retirement systems, and a number of firms did liberalize their retirement-programs."

The editorial quoted a statement by former A.M.A. President Louis Orr, Orlando, Fla., which said:

"There is no scientific reason for selecting 65 as the magic number separating the productive from the non-productive, the healthy from the unhealthy.

"In America, our attitude toward the aging has contributed to the steadily increasing number of persons 65-and-over in mental hospitals. In Japan, a society which traditionally assigns positive assets and values to aging, mental illness actually decreases with age.

"The dangers of compulsory retirement are clear and urgent."

Jacob Bleiberg, M.D.
Irvington

Martin H. Wortzel, M.D.
Newark

Apparent Increase in Diffuse Alopecia in Young Women

Hair-loss among women appears to be on the increase. Doctors Bleiberg and Wortzel cite evidence which appears to indict traction on the hair —in slavish response to the demands of style and fashion.

Shakespeare wrote in *Much Ado About Nothing*, "her hair shall be of what color it please God." Modern women refuse to leave so important a matter to the Deity. Not only the color of the hair, but its waviness, and the exact position of each tress on the head, are predetermined by the hair stylist. Many women, not content with the hair which God gave them, spend untold hours, and many millions of dollars to change it. A vast panoply of chemicals and appliances is used to accomplish the transformation. Implicit in their application is the need to manipulate and pull the hair.

Until recently, few references appeared in dermatologic literature which alluded to loss of hair in otherwise healthy women. Dermatologic textbooks, however, refer to diffuse alopecia attributable to overmanipulation. *Alopecia liminaire frontale*, first described by Sabouraud, refers to hair loss in Negro women resulting from the application of traction to straighten the hair. Also listed among the noncicatricial alopecias, are mechanical and traumatic varieties, either willful or as a result of psychoneurotic compulsion.

It is our thesis that overmanipulation of the hair as dictated by current fashion, is sufficient to produce traumatic alopecia. Our interest in this problem was aroused by a significant increase in the number of women visiting our offices and clinics for this reason. Ten dermatologists were informally polled. Six reported similar increases, one was not sure, and three reported no increase in the number of cases.

We then speculated about possible causes. One possibility was that perhaps diffuse alopecia occurs as a side effect of new drugs and antibiotics. Although improbable, this is not ruled out. We also consider it possible, but unlikely, that this picture might be a direct chemical effect from local application of cosmetic preparations and air pollutants. A recent paper in the *Lancet* incriminated the nylon hair brush. This, however, must be classed as mechanical trauma. Many women who have noticed increasing loss of hair resort to the hair brush to "strengthen and stimulate" the scalp. The exacerbated fall is frightening enough to propel them to the dermatologist, often bringing the evidence: an envelope stuffed with a mass of erstwhile "crowning glory." Frequently, the local beautician is consulted first, and the patient is sold a course of "treatments," entailing vigorous manipulation of the hair, so-called 'hot oil treatments' and thorough shampooing.

Although not a primary cause of hair loss, improper shampooing may be a contributory factor. Weekly "wash and set" is *de rigeur* for modish women. It is our contention that

the frequency of hair washing must be highly individualized, based on the amount of scalp oiliness, time of year, concentration of particulate matter in the atmosphere, occupation, and other factors.

Very few medical conditions produce more emotional turmoil than does alopecia. Dropping out of hair is a continuous process, balanced in the normal individual, by continuous regrowth. Dermatologists see some who complain of hair loss, but who show none. Attempts to reassure these people are fruitless. Frequently they manifest other evidences of anxiety, hypochondriasis or hysteria. These patients must be differentiated from women who become emotionally disturbed as a result of visible loss of hair. Also to be ruled out, are cases of hair loss following severe physical illness, surgery, or childbirth.

It is our impression that anxiety resulting from loss of hair may increase the alopecia, setting up a vicious cycle. In discussing psychologic factors in hair loss, we must say that we have been impressed with the punctuality of women in keeping beauty parlor appointments. Medical and dental appointments are broken or changed to avoid conflict with the beauty parlor appointment. The psychologic implications of this are not clear to us.

Even more mysterious are the psychologic reasons behind our failure to win the cooperation of patients in eliminating the trauma which we consider causative. When a patient is told that she is allergic to a cosmetic, an ingestant, or a fabric, she promptly agrees to the elimination of the offending substance, or to the substitution of a less allergenic material. In a sampling of fifty cases of diffuse alopecia, only three agreed to stop all procedures involving traction on the hair beyond simple combing and washing. The unanimous reason for refusal was the necessity to conform. All 47 were willing to reduce the traumatic procedures to some degree.

Improvement, manifested by less falling of hair, was reported by a majority of the patients, when excessive traction was eliminated or reduced. Most of the patients manifested slight to moderate thinning of the hair. We have seen three patients who suffered severe enough hair loss to require the use of wigs.

SUMMARY

ATTENTION is called to an increasing frequency of diffuse hair loss in otherwise healthy women. It is our impression that traction, as dictated by current hair style, is an important factor in producing this type of hair loss. Other possible, but unproved factors are enumerated.

ADDENDUM

Since this study was undertaken, two papers describing the same condition, have been published. Guy and Edmundsen, in the February 1960 *Archives of Dermatology* label this "diffuse cyclic hair loss in women." They say that: "inability to produce a reason is a salient feature of this picture." The authors quote Pillsbury, Shelley and Kligman, to the effect that certain systemic situations (physiologic and pathologic) sometimes cause the hair to enter the resting phase prematurely, after which considerable hair fall may occur. We cannot dispute this reasoning, but it fails to explain the recently rising incidence of the picture. We saw a similar increase in hair loss during the late and unlamented "pony-tail" craze. The hair loss was easily reversible, but only when a simple, non-traumatic hair style was substituted for it. Guy and Edmundsen saw improvement after systemic prednisone therapy.

In the *Archives of Dermatology* for April 1960, Sulzberger, Witten and Kopf also call the picture "diffuse alopecia in women." They term the sharp increase in the past few years striking. The authors sent a questionnaire to members of the American Dermatological Association. Out of 106 responses, 53 per cent reported an increase, 30 per cent no increase, and 15 per cent uncertain. Average estimated increase of hair loss cases was 122 per cent. Although only seven dermatologists felt that trauma *per se* was a factor, 48 more mentioned topically applied preparations, in the application of which, some trauma is implicit. The authors then say that similar increases in the number of cases of alopecia in women have been reported in France and Italy.

Significantly, Sulzberger and his colleagues say: "We are now telling our patients to stop having their hair stretched and pulled on 'rollers' for the 'high' and other coiffures which has (*sic*) been fashionable of late." These authors see no reason to interdict the use of dyes, waves and sets. If these procedures could be carried out without traction or other mechanical trauma, we would agree.

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ROBERT H. SIVER, M.D.

Baltimore

Lactobacillus for the Control of Acne

Lactobacillus is offered as a simple, safe, and "80 per cent effective" treatment for acne. It was found particularly valuable in boys and girls under the age of 18.

THE most common skin disease of adolescents is acne. Its incidence has been estimated[4] as 30 per cent in girls and 44 per cent in boys. It accounts for some 18 per cent of the disorders treated by dermatologists.[1] In the adolescent and young adult population acne is found in as high as 75 per cent of all skin eruptions.[5] This paper presents an initial evaluation of my experiences with Lactobacillus* which was found to be easily administered and was certainly helpful.

Acne is a sebaceous gland dysfunction.[8] The probable essential factor is hormonal imbalance. Other contributing factors are adaptation of adolescence, nutritional or vitamin inadequacy and emotional stress. Therapy continues to be prescribed primarily upon empiricism involving the sebaceous glands.

In my original investigation of the treatment of gastro-intestinal disturbances with a Lactobacillus preparation,[7] improvement was noted in several patients with acneform conditions. Unfortunately, gains attained with antibiotics[6] and sulfonamides, particularly in pustular and cystic acne, require a follow-up with other therapeutic measures. In contrast, the treatment of aphthous stomatitis with a Lactobacillus preparation resulted in rapid healing of the ulcers and a disappearance of symptoms.[7,9] Thus, it was desirable to consider the therapeutic effect of a Lactobacillus preparation on the clinical manifestations of acne.

TREATMENT

THE regimen was course therapy of the Lactobacillus preparation (tablets) with a rest period between. Patients were given 2 or 3 tablets three times daily with milk for a period of eight days (48 to 72 tablets), followed by two weeks with no medication. The course was resumed and repeated as many times as was indicated. The patient was instructed on care of the skin, including cleaning the skin surface, removal of the skin oil by hot compressing and the use of proper cleaning agents. Most patients showed some response during the first two weeks; more severe cases required three months. In selected patients with severe diffuse acne, I tried antibiotics for a week, followed with the Lactobacillus preparation. The tablets produced no untoward effect, whether in small amounts or massive doses. Massive or prolonged and continuous therapy was of no greater advantage.

RESULTS

IN 300 cases treated, it was found that the Lactobacillus regimen was 80 per cent effective. In the remaining 60 cases, the acne-

*The *lactobacillus acidophilus* and *bulgaricus* tablets used in this study were furnished under the trade-name of Lactinex® and were kindly supplied by Dr. George S. Warner of Hynson, Westcott and Dunning of Baltimore. Many other brands are available, including Cams® (Lacto Products), Bacid® (U. S. Vitamin Products) and other preparations under various trade-names.

form eruptions were resistant to therapy or the patients failed to follow the regimen. Half of the "effective" group showed a "reasonable" response to therapy; the other half gave a good to excellent response. The former ranged in age from 18 to 25 and typically had a history of acne for many years. On Lactobacillus therapy the pustules and local erythema faded out, but the skin remained scarred and roughened and showed residual pitting. The "good to excellent" group were in the 12 to 18 year age range. In the younger patients, the pustule formation was discreet, isolated and more noticeable. These patients had a more favorable skin to treat. During early therapy a few patients exhibited a marked aggravation with increased redness of the skin. As treatment was continued, they improved and the redness of the skin faded. Lactobacillus therapy was *not* effective in the treatment of carbuncles or large boils. Comedos did not show any results unless they were complicated by inflammatory reactions.

Case 1. A 16-year old boy gave a two-year history of "pimples" on face and back. Discreet pustular eruptions were sprinkled over each cheek and the chin. He had acneform eruptions of the shoulders and mid-scapular region. History and physical examination were otherwise negative.

The Lactobacillus preparation was taken (2 tablets, 3 times a day) with a glass of milk for 8 days. Three weeks later, marked improvement was noted, with disappearance of the pustular formation and only a slight residue of erythema. Treatment was repeated with 50 tablets as previously prescribed. A month later, his acne had sufficiently receded to warrant discontinuation of treatment. Seen two years later, the patient's face and back were completely clear and he reported no recurrence.

Case 2. A 14-year old boy gave a history of "pimples" of the face for the past two years. He had scattered comedos, a marked oily skin, and numerous erythematous papules. Some areas were edematous due to his attempt to express material from these. History and physical examination were otherwise negative.

He took two Lactobacillus tablets three times a day with milk for 8 days. Three weeks after first examination the treatment was repeated for 8 days as previously prescribed. At the conclusion of second course of treatment, most of the erythema had disappeared and the papular formation had receded. Therapy was then discontinued. Three months later, he had a recurrence. Therapy was again instituted with the same results. During a three-year period this treatment was repeated four times annually and his face remained satisfactory.

Case 3. A 17-year old boy had a five-year history of hard, tender "pimples" on face and shoulders. Examination revealed a markedly scarred, pitted nodular skin associated with old scars, fresh pustules interspersed with myriads of comedos. The back and shoulders were covered with the same lesions.

The severity of the lesions justified intensive theray. He was instructed to take the Lactobacillus preparation (6 tablets a day) with milk for 8 days. A ten-day rest period was allowed and the course repeated. This schedule (8 days treatment and 10 days rest from treatment) was continued through six cycles. No appreciable improvement was noted. Treatment was discontinued for two months and then the above procedure was repeated again. At the end of six months there was no evidence that any lesion had responded to the therapy. This case was considered as a failure.

COMMENTS

LACTOBACILLUS is not a universal cure for acne; nor does it guarantee against the return of the disease. There are recurrences which happen several months after treatment. Most of these recurrences respond again to treatment. Lactobacillus treatment may be classified as bacteriotherapy. However, clinical experience suggests involvement of the metabolic products present in the preparation and associated with the flora of the gastrointestinal tract. Interactions of skin manifestations of acne vulgaris and of metabolic processes of the intestinal tract are suggestive.

SUMMARY

LACTOBACILLUS combined with good personal hygiene was a considerable aid in the control of acne. The Lactobacillus preparation was non-toxic, produced no untoward effects, and was easily administered by physicians. It was 80 per cent effective. Patients in the 12 to 18 years of age group with early clinical symptoms of acne gave a good response to the treatments. It was less effective in patients of 18 to 25 years of age who frequently had a history of acne previous to treatment.

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Bibliography will appear in author's reprints.

E. R. Cooper

Linden

Role of Coach and Referee in Preventing Athletic Injuries*

Coaches and referees look to physicians to take the leadership in the prevention of school sports injuries. As Mr. Cooper here points out, coaches can implement the physician's role—if the doctor will accept his responsibility in school safety.

Well organized high school athletic programs help to teach young people moral and spiritual values, provide wholesome recreation, build vigor, and improve skill, strength, agility and endurance. Athletics also teach the values of competition and cooperation. These programs help players learn how to win gracefully and to retain poise in defeat. But the desire to win must never be allowed to take the fun out of athletics nor cause neglect of the basic safeguards to health.

Serious and even fatal injuries can result from high school athletics. "Body-contact" sports—such as football, basketball, hockey and wrestling—account for the highest proportion of high school athletic injuries. Other activities, like baseball and track, also take their toll. The coach is in a position to keep these injuries to a minimum.

There are two general categories of high school sports injuries—the avoidable and the unavoidable ones. A dangerous sub-category is the aggravated injury. Greatest attention should be given to the avoidable injury and the aggravated injury. It is impossible to remove completely all of the hazards from sports; after all, it is impossible to remove all the hazards from life itself. But measures can be taken by the coach and school authorities to prevent injury and permanent impairment. Tactics that may increase the hazards should be discouraged. Thus substitutions should be made without hesitation when players evidence disability or fatigue. Special attention should be given to the boy who reports late before he is permitted to scrimmage. All players should be instructed in protecting themselves in the open type of play such as kick-off and punts where being alert is a must.

On some squads, players are reluctant to report injuries and are encouraged to "run-them-off." Continued running on an injured leg or continued contact with a bruised hip often prolongs the recovery. This type of aggravated injury is much more difficult for the physician to treat and results in greater loss of time.

The vast majority of movements involved in athletics require a balance of strength in all parts of the body rather than an unusual development in one part. Hence, a general body conditioning rather than a specialized one is the most desirable during the off-season. The coach, through the use of gradnated amounts of activity, may increase the endurance and capacity of the individual to a point of peak efficiency. *A physical fitness program is not a*

*Mr. Cooper is director of health, safety, physical education and athletics in the Linden (N.J.) Public Schools. This paper was part of the "Symposium on School Athletic Injuries" sponsored April 2, 1960 by The Medical Society of New Jersey.

substitute for training in skill or endurance in any sport; however, it helps motivate a fixed "base of fitness" for all sports. A program of this kind helps prevent injuries, and adds fun to sports training that often is just plain hard work.

A responsibility like coaching must be entrusted only to well-prepared persons. Coaches must be well equipped to impart to youngsters the finest points of the game; to set an example that may be followed; and to coach in a way that best serves the interest of the youth. To do otherwise is to break faith with our younger generation. The coach must accept the fact that he is responsible for the sportsmanship and conduct of his players and also for the sportsmanship of all concerned. Unsportsmanlike conduct on the part of the players or spectators is the responsibility of the coach.

The "Bill of Rights for the College Athlete" was an idea originated by Dr. Thomas B. Quigley, surgeon to the Harvard University Health Services and Peter Bent Brigham Hospital. This received the unreserved support of its principles and provisions by representatives of the National Collegiate Athletic Association and the National Association of Intercollegiate Athletics two years ago. The document spells out four-way protection of college athletes provided by good coaching, good officiating, good equipment, and facilities, and good medical care. The adoption of such a "Bill of Rights" for the high school athlete may decrease the frequency and severity of resulting injuries.

"Too often when the big game comes and the star is still suffering from an injury, almost intolerable pressure may be exerted on the physician by the coach, students, alumni, general public, and even academic leaders, to tape up their hero and let him play." Distribution of the "Bill of Rights" will, Dr. Quigley hopes, lend moral support to conscientious physicians and coaches who need help in withstanding such pressure.

The thrill and adventure found in athletics have an unparalleled appeal for youth. When this compelling force is properly directed it can bring improved health and moral stamina to your boy and his team mates. Wrongly handled it can result in physical depletion and a totally distorted sense of values. The coach exerts a tremendous influence, not only on your boy's physical development, but on his mental attitudes as well. Unfortunately coaches are sometimes hired primarily to win games; and it may even be made known to them that their jobs depend on a winning record. Is it any wonder that the interests of the boy become secondary under these conditions? Parents are potentially the strongest force in determining school athletic policies. Parents should support the coach and the school administrator who regard their players as most important in the development of school athletics.

Most schools require a medical examination before a boy is permitted to report for a sport. If such a policy is not followed in your community, it should be. Most players will be found in sound physical condition, but the one boy who may avoid later disability through the discovery of a physical defect will justify the procedure. It is important that a *physician be in attendance at all contests. When a player is injured, only a physician should decide as to his fitness to continue play* and the coach should accept the decision. It is imperative that the players be properly conditioned to undergo the rigors of competition before they are permitted to participate in practice games. Many early season injuries may be avoided by the coach who devotes ample time for conditioning his squad. To insure a sane football program will be properly integrated with other school activities, our State Association has well defined regulations covering number of games which may be scheduled and length of season. It is important that the coach recognize these provisions. They are for the protection of the athlete.

Every coach is anxious to secure the finest possible equipment for his boys. Only the best protective pads and gear will insure maximum amount of safety for his players. He should give careful attention to proper fitting and adjustment of equipment. If not the correct size the finest equipment does not afford adequate protection.

At their annual meeting last year the lead-

ing football coaches of the United States were urged to accept medical service in preventing heat exhaustion among their valuable players. This action was taken by the American Football Coaches Association "Committee on Injuries and Fatalities" in reporting that four of 29 football players who died on the gridiron during the 1959 season were victims of heat stroke.

Recommendations made by the Mecklenburg County Medical Society (North Carolina) for dealing with perils of heat exhaustion formed the basis of these proposals by the American Football Coaches Association Committee:

1. Vigorous practice by players should be abandoned whenever the temperature exceeds 85 degrees Fahrenheit.
2. Players should be encouraged to drink at least one quart of a 0.1 per cent saline solution while practicing under conditions that cause profuse sweating.
3. Whenever the temperature exceeds 80 degrees Fahrenheit on the playing field, 30-minute periods of strenuous activity should be alternated with equal periods of rest.

The report† noted that only one other fatality because of heat exhaustion had been reported over the previous 27 years. It is not possible to determine how many cases of "near heat exhaustion" there were during the past season but these facts should alert every coach to his responsibility.

The first step in an accident prevention program is to establish a standard procedure for reporting accidents. When facts are available and analyzed preventive measures may be studied.

The adoption of a state-wide procedure for reporting athletic injuries may be desirable. The results of such a survey would provide data which may be helpful to all coaches in reducing the incidence of injuries, make coaches more cognizant of the injury problem, improve protective equipment, improve playing facilities, and provide a comparison of injuries reported in other schools. With the cooperation of the coaches and officials of 40 high schools, a survey on football injuries for the past four years has been completed. This showed:

In 1956, 35 high schools reported 760 injuries, —an average of 22.
In 1957, 46 high schools reported 1085 injuries, —an average of 23.
In 1958, 36 high schools reported 940 injuries, —an average of 26.
In 1959, 29 high schools reported 656 injuries, —an average of 22.

(To date 29 high schools have reported 1959 injuries.)

The 1958 report included 88 fractures.

The 1959 report included 44 fractures.

Average number of injuries for each squad was 23 and the number of injuries ranged from 5 to 91.

REFEREES

THE role of the referee in athletic injury prevention is also important. Good officiating promotes enjoyment of the game as well as the protection of the players. By strictly enforcing the rules and regulations unnecessary roughness is often eliminated.

A revision in the 1958 football rules requires the removal of an injured or apparently injured player for at least one down. The official is authorized to stop the clock for a player who appears to be injured.

The experienced referee may prevent an injury by blowing a fast whistle when a player is definitely stopped and is in danger of being piled on, blocked or tackled. Talking to players as a safety measure (and cautioning them not to throw the arm in the face of opponents) is sometimes effective. Control of the game in the very beginning is important and helps to prevent unnecessary rough play. The "clipping rule" (which includes any charging from behind which might cause a spinal injury) should be strictly enforced. The referee should be alert at all times to take the necessary safety measure to protect players from unnecessary injury.

A cooperative effort on the part of the coach, the team physician, the school administration, the parents and the referee may contribute much to the protection of the health and welfare of the members of high school teams.

†The report was delivered by Floyd R. Eastwood, chairman of the Committee on Injuries and Fatalities of the American Football Coaches Association.

19 East Morris Avenue

Victor Siegel, M.D.

Red Bank

Prolonged Fever in Rheumatoid Arthritis

Report of a Case Complicated by Pneumonia and Gastric Hemorrhage

Here is a puzzling and prolonged fever that finally turned out to be associated with a rheumatoid arthritis, in a patient who presented a veritable museum of symptomatology and pathology.

This is being reported because of prolonged fever with pneumonia, gastro-intestinal hemorrhage, and a final diagnosis of rheumatoid arthritis.

A 26-year old man noticed an elevated temperature of 103 and sore throat. The only physical findings were a red pharynx and some restriction of back motion. He was admitted to Monmouth Memorial Hospital in Long Branch on February 26, 1956. His condition then improved. Hemoglobin was 97.5 with a leucocyte count of 5,300, neutrophils of 57, bands 26, lymphocytes 12, monocytes 5.

Three days after admission, he developed pneumonia. His temperature rose to 105. He was cyanotic and was in an oxygen tent for 10 days. His leucocyte count rose to 22,200 with sedimentation rate of 63. Cephalin flocculation was three plus. He was placed on prednisone and antibiotics. His condition improved but his fever persisted. He noticed migratory joint pains.

He had always been sickly. "He never had any resistance against disease." He was deferred from the armed services for hypertension in 1954. He had infectious mononucleosis and infectious hepatitis in 1954.

With this past history, consideration was given to the possibility of agammaglobulinemia. He was given two injections of gammaglobulin without effect. Despite the prednisone, there was no lowering of his temperature.

On March 10, the white count reached 45,000. On March 15, he was given an injection of ACTH. For the next few days he had tarry stools and on March 16, he vomited bright red blood. Medication was discontinued, and he was started on aluminum hydroxide therapy and regular diet. At this time hematocrit was 12. Red count was only 1,900,000 but the leucocyte count was 68,500.

He was given 13 transfusions with one transfusion reaction. His general condition improved, but he continued to have a bounding fever. Muscle and lymph node biopsy, pyelogram, six blood cultures, typhoid and paratyphoid agglutinations and chest films were all negative. We then made a diagnosis of collagen disease.

On April 25, 1956, he entered the Presbyterian Hospital in New York. At that time he had a slight cough with a fever of 103. He had lost 30 pounds since February 26.

Following is a summary of the Presbyterian Hospital report:

An emaciated, chronically ill, white adult male in no acute distress. Skin is negative. *Nodes*: a few small, firm cervicals bilaterally; few small axillary nodes, left greater than right. *Chest*: clear. *Heart*: not enlarged: RSR tachycardia; Grade II precordial systolic murmur in pulmonic area. *Abdo-*

men: No enlarged organs or masses noted; suggestion of right upper quadrant mass noted after admission.

Urine, blood, nose, throat, and sputum cultures negative for pathogens. Febrile agglutinations negative. BUN-9. Trace of bilirubin. Prothrombin time: 20. Thymol turbidity negative. Alkaline phosphatase 4.6 to 6.3. Amebic complement fixation test negative. Intestinal barium enema, pyelogram, cholecystogram and proctoscopy negative. *Intestinal series*: pressure defects on distal gastric antrum and duodenal bulb by unidentified structures. Bone marrow negative. He had right bundle branch block. *Liver biopsy* showed undiagnosed condition, inflammatory liver.

COURSE

ON ADMISSION it was realized that the main differential diagnosis was: localized abscess, collagen disease or lymphoma, especially retroperitoneal. Positive findings included: prothrombin time which varied between 18 and 20 seconds despite salicylates being discontinued; alkaline phosphatase between 4.6 and 6.6; suggestion of extrinsic mass encroaching on the distal antrum and duodenum with all other radiologic studies negative; persistent sedimentation in the range of 50 to 60 with an elevated leucocyte count averaging 25,000 with predominance of polymorphonuclears. There was non-specific globulin elevation.

Throughout his hospital course, he continued to be febrile between 101 and 106 degrees daily with salicylates removing the top 2 degrees off the temperature curve. A new muscle biopsy here was unremarkable. Review of the slides taken at the Monmouth Memorial Hospital (lymph node biopsy and muscle biopsy) was negative. Liver biopsy showed small collections of leucocytes without accompanying necrosis of hepatic cells and was considered non-specific and showed only an inflammatory condition.

The patient was given a 7-day course of chloroquin, 750 milligrams daily, without change in temperature curve. He was also given a 10-day course of streptomycin with tetracycline, also without change in temperature. It was felt that laparotomy might confirm or rule out the possibility of a localized abscess (renal or hepatic). It would also serve as a vehicle for biopsy if the liver appeared abnormal or if there were any tumor masses noted. The retroperitoneal area would be examined for evidence of lymphoma. Admittedly this might not result in a diagnosis but little more could be done otherwise in the way of diagnosis.

After exhaustive diagnostic studies, with no abnormal findings (save for alkaline phosphatase of 6.3, and slightly elevated prothrombin time) the patient was transferred to the Surgical Service for laparotomy (x-rays suggested pressure defect on distal gastric antrum and duodenal bulb by unidentified structure).

On June 5, 1956, an exploratory laparotomy was done along with a prophylactic appendectomy and liver biopsy. Report of the biopsy was negative. Following operation, his course was not remarkable except for the daily spiking temperature seen prior to surgery. He was returned to the Medical Service on June 16, 1956.

DIAGNOSTIC PROBLEM

AFTER his discharge from Presbyterian Hospital, he developed wound infections at the site of his abdominal surgery. This cleared when some of the sutures came out of the wound. At this time he was taking prednisone, 20 milligrams per day, and buffered aspirin. He had evidences of Cushing Syndrome. During October 1956, he complained of pains in the right wrist. He felt "his knees were becoming stiff." He gained about 30 pounds. He returned to work in December 1956. In March 1957, he developed an elevated temperature and a blood pressure of 160/90. On fluoroscopy, a globular heart was seen. During June, he complained of severe pain in his right hip and had considerable difficulty in walking.

He bruised his right knee in December 1957, with swelling and considerable amount of pain. In January 1958, at Riverview Hospital (Red Bank) x-rays of his hip showed rheumatoid arthritis. On February 21, 1958, he was completely unable to walk and he was admitted to Monmouth Memorial Hospital where his

right hip was "pinned." He was started on gold therapy and he received physiotherapy.

At present time (October 1960) he gets about with crutches. Prednisone is maintained at 10 milligrams per day. He has a definite Cushing Syndrome.

Whenever an attempt is made to reduce the prednisone dosage, he complains of increased pain and decreased mobility of his joints. He increases his dosage himself and states that he feels better. He shows the euphoria that goes with cortisone drugs. He has the typical skin lesions as well.

SUMMARY

THIS case is reported as one of prolonged fever which finally resolved itself as acute rheumatoid arthritis a year after the original elevation of temperature; with complicating pneumonia and severe gastro-intestinal bleeding.

292 River Road

Management of Leukemia

Empirical systems of treatment, employing chemical agents and irradiation can relieve symptoms and offer the chance of an extended period of relative well-being to patients with leukemia. Whole blood transfusions and antibiotics, as the indications arise, are important if best results are to be achieved. Treatment of acute lymphocytic (lymphoblastic) anemia with steroids, the folic acid antagonists, frequently produces full remissions and, compared to untreated patients, a two-fold increase in the duration of life after onset of symptoms. In contrast, in the treatment of acute granulocytic (myeloblastic) leukemia, neither full remission nor prolongation of life occurs frequently, although some benefit is obtained. Therapy of chronic myelocytic leukemia using irradiation and administration of busulfan (Myleran) may produce full remission with great regularity; however, an accompanying prolongation of life has not been reported in most series. In chronic lymphocytic leukemia irradiation and chemotherapeutic agents such as chlorambucil, triethylene melamine, nitrogen mustard, and steroids may produce remissions which are often not as complete as in chronic myelocytic leukemia, but symptoms are often less severe, the disease is more indolent, and, in the experience of some workers, longevity is greater.—A Haut, M.D., American Journ. of Medicine, 28:777 (1960).

Ars Longa: Vita Brevis

When Hippocrates enunciated his aphorism, "The art is long; life short," medicine had little more than "the art" to offer. We now have art and science; but our training is concerned entirely with the latter. Our patients, however, expect from us more than scientific knowledge, skill and clinical judgment in the physician-patient relationship; they take that for granted when they choose a physician. Our patients expect sympathy, understanding, and intellectual honesty in the physician. A thorough grounding in the humanities during premedical education and continuous follow-up in these areas of thought and knowledge throughout our medical training would better prepare us and future physicians to render the medical attention that our patients need for complete satisfaction.—A. F. Hall, M.D., Arch. Derm., 82:222 (1960).

HERSCHEL S. MURPHY, M.D., *et al.**

Roselle

The Treatment of Threatened Abortion

This is part of a nationwide study of the effectiveness of an intensive treatment program for threatened abortion. In early pregnancies, the successful live birth ratio was 50 per cent. On this regime, it was 90 per cent.

ONE of the most difficult problems in medical practice is that of satisfying the natural biologic demands for motherhood in patients who, time and again, abort their pregnancies. Much is known of the involved physiology and pathology of this problem; however, basic research in conservation of fetal life has lagged far behind the dramatic advances in other areas of obstetrics.

The U. S. Public Health Service[1] shows that 23 per cent of all pregnancies in the United States in 1951 failed to deliver a live baby. As late as 1956, we find that 22 per cent of all recorded pregnancies ended in failure. During the five-year interval a reduction of less than one per cent of fetal deaths was accomplished by medical treatment which, by and large, was empirical. This small increase in fetal salvage should encourage further investigation of the problem of threatened abortion to ascertain procedures for better management.

Mall and Meyer[2] in 1921, and Malpas[3] in 1938, reported the incidence of threatened abortion in their series to be 18 per cent and 22 per cent respectively. Through the years many recommendations have been advocated in treating patients prone to abort. Kotz[4] and his associates, in 1941, concluded that progesterone is of definite value in habitual abortion in conjunction with natural or synthetic vitamin E.

Wall and Hertig[5] showed that 62 per cent of abortions occurred as a result of ovular factors and 38 per cent from maternal factors. The majority of ovular factors result in pathologic ova while the maternal factors include induced abortion, uterine abnormalities, infections, febrile diseases, and emotional conditions. Hypothyroidism may contribute as well as relatively low progesterone blood levels.

Kistner[6] summarized his suggested management of habitual abortion with a program of treatment consisting of reassurance and alleviation of fears, a nutritious diet with hematinics, bioflavonoids, ascorbic acid, and if necessary, thyroid medication.

Javert[7] obtained an 80 per cent successful outcome of fetal salvage among a large group

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*Participating Physicians, Herschel S. Murphy, M.D., Chairman Emeritus, Obstetrical Department, Rahway (New Jersey) Hospital; Ernest C. Lowenstein, M.D., Rahway Hospital; Archibald K. Maness, M.D., Cone Memorial Hospital, Greensboro, North Carolina; Harry T. McFarland, M.D., Good Samaritan Hospital, Cincinnati, Ohio; Edward R. Farrage, M.D., Mercy Hospital, Council Bluffs, Iowa and Floyd D. Gindhart, M.D., of the Helene Fuld Hospital in Trenton, N. J.

1. U. S. Department of Health, Education and Welfare: Fetal Deaths, 48:13 (October 7, 1958).

2. Mall, L. P., and Meyer, A. W.: *Contrib. Embryol.*, 56:12 (1921).

3. Malpas, P. J.: J. Obst. and Gynec. of the Brit. Emp., 45:932 (December, 1938).

4. Kotz, J., Parker, E. and Kaufman, M. S.: J. Clin. Endocrinology, 1:838 (1941).

5. Wall, R. L., Jr. and Hertig, A. F.: Amer. J. Obst. and Gynec., 56:1127 (1948).

6. Kistner, R. W.: *Medical Science*, 59:782 (1959).

7. Javert, C. T.: Obst. and Gynec., 3:420 (1954).

of women suffering from repeated abortion through the use of preconceptional consultations and the correction of medical, gynecologic, and psychologic difficulties, plus high citrus diet including hesperidin, vitamin K supplement daily, thyroid extract as indicated, psychotherapy, and sedatives. He also explained the stress-hysterosthenia gravis hypothesis as a causative factor of the onset of uterine contractions (premature, miniature labor), decidual hemorrhage, and premature rupture of the membranes. This triad may be the recurring factor causing spontaneous, habitual abortion.

A therapeutic program using chorionic gonadotropin, a natural estrogen, and progesterone by mouth, in addition to conventional methods, has been outlined by Wilson [8] for habitual abortion. This regime should be tried *before* there are clinical signs of threatened abortions. This treatment is based on the concept that these endocrine substances can help a woman maintain a normal environment for the fertilized ovum and that the extreme fluctuations in endocrine production can be maintained. Falls,[9] in discussing Wilson's paper, stated, "We were able at the Cook County Hospital with the use of progesterone to change the incidence of salvage in threatened abortion from about 35 per cent to 89 per cent in over 400 patients."

Greene [10] and Turner [11] recognized that ethisterone, the hormone of nidation, was responsible for preparing the uterus for implantation of a fertilized ovum and for nourishing and protecting the conceptus as well as relieving the spasticity that occurs with threatened abortions. Ethisterone, a progestational hormone, is absorbed in the intestine. A 5 milligram oral dose is equal to the effectiveness of 1 milligram of progesterone intramuscularly.

Allen [12] suggests vitamin K in threatened abortion since it stimulates the liver to produce prothrombin, thus prevents hypoprothrombinemia which is frequently associated with bleeding tendencies during pregnancy. Vitamin E, often called the "fertility" vitamin, was mentioned by Sheffery [13] and Shute [14] as valuable in improving fetal salvage in many nutritionally inadequate patients. Also, ascorbic acid levels are frequently low in habitual abortors and large amounts of citrus juice and heperidin were recommended [15] in therapy to protect decidual vessels by maintaining capillary tonus.[16]

From the various reports, it becomes obvious that a program for threatened abortion should include a comprehensive study of all factors that have potential etiologic significance, *i.e.* emotional aspects, nutritional states, hematologic disorders, anatomic defects, and hormonal insufficiency.

METHOD OF STUDY

THE participating physicians* from various sections of the United States desired to improve fetal salvage by instituting a study to evaluate a regimen of dysabortive therapy in selected patients exhibiting symptoms of potential or habitual abortions. Classification of patients was as follows:

Potential abortors: patients with persistent symptoms of vaginal bleeding (spotting) or cramps and/or intermittent pains. Also, abortion proneness induced by endocrine or metabolic dysfunction.

Habitual abortors: patients who have a previous history of aborting three or more times.

Conscientious efforts were made to rule out reproductive abnormalities such as uterus didelphys, bicornate or septate uterus, fibroids, cysts, or infection. Each physician used identical case history charts with particular references to (1) past history, (2) laboratory tests, (3) length of gestation, and (4) delivery data. Incidents of scarlet fever, measles, mumps and nature of Rh factors were correlated to determine their significance as a contributing cause to the patient's present status as an abortor.

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8. Wilson, R. B.: Amer. J. Obst. and Gynec., 69:614 (1955).
9. Falls, F.: Discussion of Paper on Habitual Abortion in the Amer. J. Obst. and Gynec., 69:626 (1955).
10. Greene, R.: *The Practice of Endocrinology.* Eyre and Spottiswoode, London (1951).
11. Turner, C. D.: *General Endocrinology.* Saunders, Philadelphia (1948).
12. Allen, J. G.: Amer. J. Med. Sci., 205:97 (January, 1943).
13. Sheffery, J. B. and Dill, L. V.: Medical Clinics of North America, 31:696 (May, 1947).
14. Shute, E.: Urologic and Cutan. Rev., 47:239 (April, 1943).
15. Javert, C. T. and Finn, W. H.: Texas Journal of Medicine 46:739 (1950).
16. Greenblatt, R. B.: Ann. New York Acad. Sci., 61:713 (July, 1955).

TREATMENT

PATIENTS are best investigated for etiologic factors in the nonpregnant state so that effective therapy can be instituted *prior to* or in the cycle in which pregnancy occurs. Eighty-six obstetrical patients exhibiting past histories or present symptoms of threatened abortion were managed by a dysabortus regimen which consists of the following categories:

Diet: All patients were urged to eat high-protein foods including lean meat, cottage cheese, leafy green vegetables, together with a high intake of citrus fruits, as well as gelatine, custard, eggs, and milk. Salt intake was restricted in all cases.

Rest: Patients classified as habitual or potential abortors were encouraged to have a daily rest of from ten to twelve hours with a one to two-hour afternoon nap. If needed, sedatives were usually prescribed. Patients were urged to refrain from long trips and strenuous exercises.

Emotional: Regardless of the number of miscarriages, reassurance to the patient for a potential future family is always needed. It was our desire to establish confidence of patients by our ability to cover their needs 24 hours a day. We encouraged the patients to call the office any time during the day or evening as desired; particularly if there was a problem that caused emotional tension. When such calls came through the answering service, they were immediately relayed to us. As soon as feasible we called the patient to allay her fears. The nature of the problem would determine whether an office visit or house call should be made.

We have found it necessary for creating peace of mind to answer all questions posed by the patient whether during office visits or *via* telephone. We never assumed that any question was too trivial or unimportant. Usually we called the patient between 4 and 5 p.m. once a week to ask whether she had any problems. This personal interest built confidence and loyalty. When feasible, regular attendance at expectant mothers' classes was recommended to augment practical education. Also, literature on prenatal care was given to all patients.

Office Visits: Patients with symptoms of threatened abortion were encouraged to make frequent visits to the office. Thus, potential abortors were seen every 3 or 4 weeks; habitual abortors every 2 weeks.

Sexual Activity: Potential or habitual abortors are apprehensive and are sensitive to trauma. It is, therefore, mandatory for them to abstain from coitus until fetal life is felt. Thereafter, frequency of coition depends on the advice of the attending physician. We recommend that during coitus, the female should assume top position to eliminate pressure on the abdominal region and minimize sexual trauma which may cause uterine bleeding. Abstinence from coition during the time when menstruation would have occurred is suggested.

Thyroid Medication: Blood counts and basal metabolism rates are recommended if there are any indications pointing to the need for thyroid medication.

Evidence of the sudden onset of hypothyroidism in early pregnancy as a cause of abortion is somewhat questionable. However, the presence of thyroid hormone is almost always necessary for successful pregnancy. The hypothyroid patient should receive treatment prior to and during pregnancy. There is a disagreement about what constitutes true hypometabolism.[17] Only indirect methods are available to diagnose the activity of the thyroid gland. Protein-bound iodine determinations and radioactive iodine uptake reflect only thyroxin production rather than tissue utilization.

Hormone-Vitamin Supplement: From the composite of opinions by other clinicians reporting on threatened abortion we concluded that a combination of hormone-vitamin supplement was advisable for the maintenance of gestation. We used Ethisterone (15 milligrams), Vitamin K (2.0 milligrams), Vitamin E (3.5 milligrams), Hesperidin 175 milligrams) and Vitamin C (175 milligrams). The dosage of hormone-vitamin supplement† was prescribed according to the needs of our patients. Habitual abortors received continuous therapy consisting of three tablets daily started as soon as pregnancy was diagnosed and continued throughout gestation. Intermittent therapy was prescribed to potential abortors. They received three tablets daily for six weeks or a sufficient period of time to carry them through the next potential menstruation. This program was reinstituted periodically or when symptoms reoccurred. It is safe to double the dose for a week or ten days, if necessary.

RESULTS

AMONG our 86 patients, the incidence of measles and mumps was 87 per cent and 80 per cent respectively, with only a 20 per cent incidence of scarlet fever. In our group, incidence of infectious diseases was not, therefore, a major contributory factor to their present obstetrical problem. Blood cell counts and urine analyses were all within normal limits. However, an incidence of 30 per cent Rh negatives is significant since it is double the ratio in the population at large.

Comparison of the length of gestation of previous pregnancies with present deliveries is shown in Table I.

17. Barnes, A. C.: Clinical Obstet. and Gynec., 1:203 (March, 1958).

†Several hormone-vitamin combinations are available from pharmaceutical manufacturers. Some physicians may prefer to make up their own combinations varying this formula, or prescribing separate medications to be taken together or consecutively by the patient. In this project we used the preparation trade-named as Nugestoral® (Organon-Orange, N. J.).

TABLE 1.

LENGTH OF GESTATION

Month	Previous Pregnancies	Present Pregnancies
1	6	0
2	34	0
3	46	3
4	12	1
5	6	1
6	5	1
7	4	0
8	3	2
9	119	78
Per cent at 9 mos.	51%	91%

Delivery data of 86 patients are as follows:

Spontaneous	56	
Cesarean	5	
Forceps	17	
Stillborn	2	(8th month)
Miscarriage	6	

Average weight of the 78 live babies was seven pounds, five ounces.

Pregnancies from a regime of dysabortus therapy are compared with previous pregnancies by the same group of patients *without* dysabortus therapy. Results are summarized in Table 2.

TABLE 2.

STATUS OF PREGNANCIES

	Type of Therapy	
	Without Dysabortus Therapy	With Dysabortus Therapy
Number of Pregnancies	236	86
Number of Live Babies	119	78
Proportion of Pregnancies Producing Live Babies	51%	91%

Table 2 shows that when the special regime was followed, 91 per cent of the pregnancies were successful, yielding live babies; whereas, without the special program, only 51 per cent were successful. This 40 per cent improvement of results was striking. Of the 86 women who received dysabortus therapy, 71 were potential abortors and 15 were habitual abortors. The composite of patients classified as potential or habitual abortors with respect to the success of presenting a live baby is summarized in Table 3.

TABLE 3.

COMPOSITE OF PATIENTS

Type	Number of Pregnancies	Success	Ratio	Failure	Ratio
Potential Abortors	71	65	92%	6	8%
Habitual Abortors	15	13	87%	2	13%
Total Patients	86	78	91%	8	9%

Sixty-five (92 per cent) live babies were obtained from the 71 potential abortors with six (8 per cent) failures. Also, 13 (87 per cent) live babies were obtained from the 15 habitual abortors with only 2 (13 per cent) failures; one of which was a stillborn (8th month).

COMMENT

MASCULINIZATION or other side effects to mother or baby were not observed during the five-day hospital stay or at the routine postpartum study of six weeks. These were all private patients. On leaving the hospital, the mothers selected different pediatricians for their babies. We were, thus, not able to follow-up the babies beyond the first six weeks to determine any possible abnormalities. Such a program with a three-year follow-up would be desirable to see if there were maternal or infant side effects from dysabortus therapy.

Our proportion of live babies from 86 pregnancies was so encouraging that we plan to develop another series and compare it with the group here reported.

Some of our obstetrical colleagues suggested we try dysabortus therapy on pregnant patients with hookworms. They felt that hookworms were contributory to threatened abor-

tion. Such patients will, if available, be included in our second series of evaluation of dysabortus therapy.

SUMMARY AND CONCLUSIONS

A REGIME of dysabortus therapy is presented. This includes diet, rest, emotional reassurance, restricted sexual activity, thyroid medication (when indicated) and hormone-vitamin supplement. Eighty-six pregnant patients, classified as potential or habitual abortors, followed this program. Attempts were made to rule out maternal abnormalities in evaluating the dysabortus therapy. Live babies were delivered to 91 per cent of the women who received dysabortus therapy. This was an increase of 40 per cent over the untreated series. No side effects or masculinization to mother or baby were observed. Incidence of infectious diseases (with the possible exception of the negative Rh factor which was twice the normal distribution), were not causative to the obstetrical problem of threatened abortion.

We conclude that the dysabortus therapy as presented is an effective regime for treatment of threatened abortion. In our hands fetal salvage has been materially increased.

320 Chestnut Street

Discharging Nipples

Serosanguineous discharge from the nipple usually indicates a pathologic process involving the breast ducts. There are two schools of thought in regard to its significance. One stresses the frequency with which cancer of the breast may be associated with such a discharge. The other school stresses the frequency with which benign conditions, such as intraductal papilloma, produce bleeding. The authors review 67 patients with discharge from the nipple, who were found among 810 patients with breast disease followed-up in the Georgetown University Hospital from 1947 to 1959. The nipple discharge was bloody in 27 and serous in 40. There were 24 women with breast cancer, 1 man with neurogenic sarcoma of the breast, and 42 women with benign breast lesions. In the patients between 20 and 49 years of age nipple discharge was associated with benign lesions more than twice as often as with malignant lesions. Among patients over 50 years of age discharge from the nipple assumed an increasingly serious significance. Cancer was found in eight of the 11 patients over 50 years of age who had a bloody nipple discharge. A breast with nipple discharge but without a palpable mass must be suspected of harboring a cancer until this has been disproved. Treatment includes: progesterone therapy in selected cases; local excision of lesion or of localized parenchymal source of bleeding; simple mastectomy under certain conditions; radical mastectomy if cancer is found.—A. M. Copeland, M.D., Annals of Surgery, 151:638 (1960).

Geographic Tongue

This nonmalignant disease is characterized by denuded patches surrounded by thickened skin tissue—the tongue resembles a relief map. It is usually resistant to therapy and tends to persist. Kipping reports on a woman with a 14-year history of the condition. The patient was treated with prednisolone for a skin eruption. After three weeks of treatment she said this was the first time in 14 years that her tongue had completely cleared.

A.M.A. Archives of Dermatology, September 1959.

Benjamin A. Brown, D.D.S.

Ventnor

Prevention of Dental Injuries in Sports*

Half of all football injuries involve trauma to the face and teeth. A simple and inexpensive mouth-guard will prevent most of these disabilities. Dr. Brown here presents the requirements for the prevention of dental injuries in athletics.

Dental injuries occurring during athletic events may be prevented or materially reduced if sound preparation is made and educational information disseminated in advance and repeatedly emphasized. Dental injuries in sports is one of the projects of a committee of our State Dental Society. I shall quote freely from their findings and recommendations.

Let me start with quoting a recent item from a Wisconsin newspaper:

"Nearly 6200 high school students were injured in Wisconsin in interscholastic athletics in the 1958-59 school year, and the injury rate is running even higher this year." The report was made by the Wisconsin Interscholastic Athletic Association, which operates an insurance benefit program that pays claims for athletic injuries. Wisconsin is the only state in the union with such a program.

"The 1958-59 total represented an increase of 800 injuries over the previous school year. Some high school coaches attribute the injuries to the poorer physical condition of boys."

"The 6200 injuries occurred among 38,787 boys participating in interscholastic athletics. Claims totaled $123,517. Football resulted in the greatest number of injuries (3,984) and was more than three times as costly as any other sport, with a claim total of $88,560. Basketball, with 1,184 claims totaling $19,258, was next."

"The injuries varied widely in severity. There were 2,331 visits to physicians for injuries so minor that no listing was made. The total of 6,200 included 9 concussions, 1,796 sprains, 511 tooth injuries, 11 kidney injuries, 438 lacerations, 39 abrasions, 1 spleen injury, and 265 fractures. The fractures: finger, 156; foot, 41; ankle, 41; clavicle, 68; elbow, 11; and femur, 8."

As you can see dental injuries rank high in this list. These 511 tooth injuries are of vital concern to the dental profession.

One of the most disheartening things for a dentist to hear is that a young person has fractured his front teeth, which sometimes does occur during a "contact sport." It is disheartening because such injuries *are preventable* and because the teeth *will need not only emergency treatment, but also attention for the rest of the person's life. A fractured tooth, unlike a broken arm or leg, will not heal. Damage to the tooth is always permanent.*

Because of the stage of development of the oral structures in the 12 to 16-year age group, injuries to the teeth are difficult to repair. Owing to the enlarged dental pulp during this period, preparation of a front tooth for a porcelain jacket crown or bridge abutment presents problems. Loss of or damage to a back tooth creates problems. Repair is costly and time consuming, but prevention is inexpensive and easy to accomplish.

The 1954 *Handbook of the National Federation of High School Athletic Associations* lists the incidence of football injuries as follows: Face and dental 54 per cent; knee 20 per cent; shoulder 13 per cent; head 9 per

*Adapted from a talk given at Seton Hall University April 2, 1960 as part of a symposium on athletic injuries. This program is a project of The Medical Society of New Jersey. Dr. Brown is President (1960) of the New Jersey Dental Society.

cent; pelvic 4 per cent. In view of the high proportion of facial and dental injuries, it seems imperative that more mouth protection be provided.

Schools spend on an average of $90 to $120 annually to outfit each player with protective clothing. This affords protection only for those regions in which 48 per cent of the injuries occur. A comfortable, well-fitting mouthpiece costs less than a pair of football shoes. It should become standard equipment.

Dental scientists pointed out the need for mouth protectors as far back as 1927 when boxers sought protection from blows to the mouth that sometimes resulted in death. The use of mouth protectors during "contact sports" is not a new thing. For several years our U. S. Naval Academy football team has been using them with good results. The Universities of North Carolina, Texas Western, Syracuse, Ohio State, Yale and numerous others have had equal success. In 1958, the Board of Education in Philadelphia directed that 375 high school football players be fitted with special latex mouth guards. In New Jersey, several high schools have equipped their players with mouth protectors. In 1957, several Hackensack dentists undertook a program of supplying the high school football players with mouth protectors. The record in Hackensack of *no fractured teeth* speaks for itself.

A SHARP decline in the number of tooth and brain injuries among high school football players who used fabricated tooth guards as standard equipment was reported by the University of Pennsylvania.

Dr. Abram Cohen, of the University Dental School faculty, said only one tooth injury and one concussion were reported among the 713 Philadelphia schoolboys who used the tooth guards in 1958. But in 1957, when no mouth guards were used, there were 21 tooth injuries and 26 concussions in the same schools. These mouth guards were prepared by students at the dental schools of Temple University and Pennsylvania. One type was molded latex, the other a harder plastic material called Impak®.

Half of the school boy players were fitted specially with the latex guard in a special "project mouth piece" at the University of Pennsylvania. Temple fitted the boys with the plastic mouth guard. These guards protect teeth by holding both jaws in a firm position, thus preventing them from banging against each other.

Concussions from football injuries generally result from the lower jaw jamming back and up toward the lower rear section of the skull. The mouth guard prevents or limits, the jamming, by being held in the teeth.

On the basis of a survey of some of the available reports the following suggestions are submitted:

The *purposes* of a mouth protector are (1) to cushion the teeth against direct contact with one another; (2) to protect the lips and cheek against cuts and bruises due to external and internal trauma; and (3) to cushion the effect of a blow to the lower jaw, which otherwise might result in forcing the condyle head upward and backward against the skull, thereby causing a brain concussion.

Requirements: The mouth piece must be reasonably comfortable, must remain in place when the mouth is open, and must not impede breathing or interfere with speech.

Types: The advantages and disadvantages of the available means of mouth and tooth protection have been studied. We are aware of the availability and usefulness of various types of face masks, bars and cages, of fiber, plastic and metal, attached to helmets.

These devices protect the face. They do not adequately protect the teeth. Teeth become injured most frequently from blows under the chin, in spite of these face protectors. A soft vellum rubber or vellum acrylic splint fitted to the upper arch results in the best protection. This type of protector can be made easily and is not costly. A custom-made device has the advantage of being more comfortable than a commercial type because it is more easily contoured and fitted to individual requirements.

Of the commercial types, two mouth protectors seem satisfactory: Featherbite® and Voit®. Both are soft vellum rubber horseshoe-shaped devices with buccal and lingual surfaces. Between the two flanges is a thermoplastic material which can be adapted to the

teeth and chilled to retain the shape of the upper dental arch.

Some coaches are reluctant to adopt a mouth piece, because they confuse it with the old fashioned type which had to be held between the teeth and removed to call signals or to speak. Coaches who have tried the modern mouth piece are enthusiastic. To be effective, a mouth piece must fit the individual's mouth, afford adequate protection, stay in place comfortably and securely, and allow mouth breathing and speech. Young men and women will wear a comfortable, well fitting mouth piece.

A survey conducted by the Security Life and Accident Company demonstrates that the inexperienced sports participant suffers the largest incidence of injuries and needs a mouth piece as much as any other piece of equipment.

To augment the work presently being done by a variety of agencies to minimize or eliminate injuries resulting from "contact sports," the purpose of this presentation has been to acquaint you with the mouth guard and to suggest incorporation of the dentist into athletic programs. Here he can emphasize the need for dental care and the maintenance of good dental health to the youth and, through him, to his parents. This guard provides mouth protection to the youth at a modest price.

Injuries to teeth in "contact sports" are preventable. A successful program of compulsory wearing of mouth protectors will be achieved only by cooperation of parents, school officials and athletic directors. All persons responsible for the physical welfare of our youth must be informed of the desirability of protection against injury of the teeth. When they are convinced of the necessity of such a preventive program, they will insist that all players in "contact sports" wear mouth protectors.

5615 Atlantic Avenue

Distribution of "March of Dimes" Funds

New Jersey has been the principal beneficiary in the allocation of March of Dimes funds raised in our state over the past 23 years. So says The National Foundation in a January 1961 release.

More than 52 cents of every dollar from New Jersey's March of Dimes has been put to use in aiding our state's disease victims and in research projects conducted by New Jersey institutions. Much of the remaining 48 per cent comes back to New Jersey in shipments of vaccine and gamma globulin and in other nationwide services conducted by The National Foundation.

Since 1938, New Jersey chapters of the March of Dimes raised 16 million dollars at an average fund-raising cost of 10 per cent. Of this amount, 8 million has been available to the county chapters in carrying out their extensive patient aid programs, including advances of more than a million dollars from the national office to meet emergency situations in New Jersey. In addition, eleven grants totaling $500,000 have been made in support of research projects in New Jersey institutions.

Above the 52 per cent used directly in our state, The National Foundation has financed within New Jersey projects such as the historic field trials (which proved the effectiveness of the Salk vaccine) epidemiologic studies and Fellowship grants to New Jersey residents. National headquarters' expenditures for the vaccine trials in New Jersey alone amounted to $132,000. The national office has sent into New Jersey $68,000 worth of Salk vaccine and 275,000 cubic centimeters of gamma globulin in support of its poliomyelitis prevention programs.

Two years ago, the National Foundation for Infantile Paralysis changed its name to The National Foundation in expanding its areas of interest beyond poliomyelitis to include birth defects and arthritis, using the scientific knowledge and experience gained in the fight against poliomyelitis.

Trustees' Meeting: November 20, 1960

Following is an abstract of the major actions taken by our Board of Trustees at their meeting in Trenton on November 20, 1960.

There was a discussion of the tradition of the "Presidential Reception" at our Annual Meetings. The usual practice has been for the "home society" of the incoming President to sponsor a reception in his honor. Larger component societies have an expanded guest list for these receptions. Because of the cost, smaller county societies have found it necessary to limit the guest lists. It is becoming more and more difficult for the county societies, particularly the smaller ones, to finance such receptions. It is suggested that the State Society underwrite a portion of the cost on the following basis:

1. Have the reception on Sunday evening beginning at 9:00 p.m., which will give everyone a chance to have dinner;
2. The home county society of the incoming President to be the official host; all members and their wives and official guests to be invited; and a non-alcoholic punch be served.
3. Following the formality of the official reception, approximately an hour to an hour-and-a-half later, have dancing and a Dutch-Treat bar in an adjacent room.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that this suggestion be adopted.

The President of the Woman's Auxiliary makes the following suggestions concerning Auxiliary activities at the annual meeting:

1. *Auxiliary Luncheon*—It has proved difficult for the President, President-Elect, and Executive Officer to find sufficient time from the business meetings to attend the Auxiliary luncheon. It is suggested that an official Society spokesman be appointed by the President to bring official greetings to the Auxiliary.
2. *Fellowette's Key*—It has been the custom for the President of The Medical Society of New Jersey to present the retiring President of the Auxiliary with her Fellowette's Key. If a change is made in the procedure for the Auxiliary luncheon, it is suggested that the key be presented at the annual banquet.

Dr. Bedrick moved—seconded by Dr. Kaufman, and carried—that, if these arrangements meet with the approval of the President, they be carried out.

Dr. Jehl reported that the Passaic County Medical Society has raised over $1,000 toward the $5,000 goal for the Joseph E. Mott Memorial Grant of the Medical Student Loan Fund. A check will be forwarded to the Fund shortly.

MEDICAL STUDENT LOAN FUND

The Board has requested our Woman's Auxiliary to emphasize the collection of contributions to the Medical Student Loan Fund. A communication was received from Mrs. Ralph K. Bush, president of our Woman's Auxiliary, assuring the Board that steps had been taken to assure compliance with that request.

REPORT OF THE PRESIDENT

Dr. McCall stated that an invitation had been received from Dr. Kandle, State Commissioner of Health, for our Medical Society to co-sponsor a "workshop" in the spring of 1961 on "Continuity of Care." This two-day colloquium will be directed toward the administrative level of agencies with interest and responsibility in health, welfare, and related services. Two one-day workshops in local areas will follow, directed toward the service level. Other agencies being invited as co-sponsors are: Seton Hall College of Medicine and Dentistry; State Department of Institutions and Agencies; State Department of Health; State Division of Aging; The Social Work School of Rutgers University; State Department of Labor and Industry; State Committee on Continuity of Care; New Jersey Heart Association; Region II of the Department of Health, Education and Welfare; and the U. S. Public Health Service. A preliminary planning meeting of co-sponsor representatives will be held shortly.

Dr. Blaisdell moved—seconded by Dr. Bowers, and carried—that the Society accept the invitation to be a co-sponsor of the program.

The Board of Trustees of the New Jersey State Safety Council will meet on November 28, at which time Dr. McCall—who is a member—will be in Washington attending the AMA Clinical Session. He suggested that Dr. Maldeis be authorized to represent him at the Council meeting. Dr. Maldeis is chairman of our Special Committee on Traffic Safety. This suggestion was adopted by the Board.

REPORT OF EXECUTIVE COMMITTEE

Last August the Board approved the establishment of an Advisory Committee to review MSP and HSP disputed claims. The following personnel for the committee are now proposed by the President and the Executive Committee. These are designated on a judicial district basis, with alternates to attend meetings in the absence of regular members.

Regular Members

District

1. F. Clyde Bowers, M.D., Chairman
2. John J. Bedrick, M.D.
3. Gerard R. Gessner, M.D.
4. Reuben L. Sharp, M.D.
5. Nicholas E. Marchione, M.D.

Alternate Members

District

1. Elton W. Lance, M.D., Alternate Chairman
2. Robert A. Cosgrove, M.D.
3. John A. Kinczel, M.D.
4. John C. Clark, M.D.
5. John S. Madara, M.D.

Dr. Kaufman moved—seconded by Dr. Collins, and carried—that the list of regular and alternate members of the new committee be approved.

As directed by the Board two resolutions will be re-introduced into the AMA House of Delegates: (1) Intern Program, and (2) Foreign Medical Graduates. The Executive Committee felt that these are of vital concern to the hospitals of New Jersey and their staffs. It requested that a letter be sent over the President's signature to medical directors of hospitals of New Jersey informing them of the planned introduction of these resolutions and suggesting that they may wish, as an expression of interest, to be present at and participate in the discussions before the Reference Committee on Medical Education and Hospitals on Tuesday, November 29 in Washington, D. C.

REPORT OF SECRETARY

Since publication of the 1959-60 Directory, all changes reported to the Executive Offices have been recorded and forwarded to the printer who has revised his copy accordingly. At the end of each month the printer's copy is completely current. It is recommended that a notice be carried monthly in the *Membership News Letter* and in THE JOURNAL urging each member to review his listing and to submit any changes to the Executive Offices. If this is done, we could eliminate the mailing of listings to individual physicians, thereby effecting substantial savings in the printing cost of the Directory and in the working time of office personnel. The next edition could then be printed and distributed early in the summer of 1961.

Mr. Nevin had suggested that the initial contact with the membership be by first-class mail informing them that the Directory will be published next summer and asking them to notify us of listing changes. He also suggested that a reply postal be included with the letter on which the member could indicate: (1) that his listing is all right as it appears; or (2) his listing is to be changed, with the corrections noted. In the months following this mailing the follow-up notices could be carried in the two publications.

Dr. Greifinger estimated that the cost entailed in the suggestion offered by the Executive Officer would be about $750. To follow the directory publication routines of past years would require the employment of additional help at a cost of four to five thousand dollars.

Dr. Allman agreed that the members are sufficiently aware of their responsibility to supply the Office with listing changes; and that notices in the two publications would be enough to alert the members to the fact that a new Directory is being prepared and for them to send in whatever changes they want made. It was his belief that the returns from a first-class mailing would not be much greater than the response to the published notices, and therefore he did not approve of the expenditure of $750 for a mailing.

Upon motion by Dr. Allman—seconded by Dr. Buchanan, and carried—the recommendation of the Secretary was approved.

Dr. Wegryn suggested—and the Board agreed—that the secretaries of the component societies be alerted as to procedure to be followed in the preparation of the copy for the 1961-62 Membership Directory; and that they be urged to stimulate their members to send

listing changes to the Executive Offices promptly.

Twenty years ago, our Society held dues-paying membership in a "Conference of Professional Societies." One of the objectives of this Conference was to prevent the consolidation of the professional examining and licensing boards into one department to be handled by a non-professional state employee. The organization has been dormant for many years. The former Secretary of the State Board of Pharmacy, Dr. Robert P. Fischelis, was Secretary-Treasurer of the Conference. He has reported that the Conference bank account amounts to $621, and that he wants to dispose of the funds. After discussion with some of those who were active at the time the Conference functioned, he drew checks for $120 to each of the five major organizations which had participated in the Conference: Medical Society, Dental Society, Nurses' Association, Optometric Association, and Pharmaceutical Association; retaining the balance of $21.42 to cover postage, travel, and clerical expense in connection with closing the account.

Dr. Fischelis requested the Society to accept the pro-rated check of $120 on this basis and to sign a release therefor.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried—that the check for $120 be accepted as the Society's pro-rated share of the funds of the Conference of Professional Societies, and that the Secretary be authorized to sign an agreement to the closing of the account on the basis indicated. And, on motion of Dr. Greifinger, it was agreed that this money be contributed to the Medical Student Loan Fund.

MEDICAL-LEGAL TESTIMONY

As directed by the Board, a committee met to consider the format of the proposed rules (governing impartial medical expert testimony and a professional liability panel), and to submit any proposed revisions to the Court's Administrator. The report of the New Jersey Supreme Court's Committee on Expert Medical Testimony was studied in detail. Two slight additions to the text were agreed upon and transmitted to the Court's Administrator.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried—that the action of the committee be approved, and that the report be accepted.

Mr. Nevin reported that with Dr. Allman, Dr. Wegryn and Mr. Backes, he had attended the Judicial Conference on November 18. In the discussion dealing with medical expert testimony there was considerable opposition. It was felt that medicine is not an exact science; it does not guarantee that an expert's opinion would be right; that such an expert coming into Court would sway the jury; and that his findings would be tantamount to decision and the Judge would have no function beyond that stage. This is in opposition to the adversary practice of law. Judge Labrecque, President of the Bar Association, also spoke against the proposal. Many trial lawyers voiced opposition. Indeed, no one in the audience spoke for it. Justice Steuer of the New York Supreme Court was a forceful speaker in favor of the plan, and Judge Waugh of the New Jersey Superior Court spoke in support of it. Mr. Nevin expressed doubt that the proposal for such medical expert testimony will ever come to pass in New Jersey in view of the overwhelming opposition evidenced at the Judicial Conference.

Dr. Kaufman voiced disagreement with this doubt. The committee has known all along that the trial lawyers would be opposed. The Supreme Court Justices favor the Rule and that was the reason behind the recommendation for a pilot study in the four counties of our first district. He stated that the Justices are anxious to try it on pilot study basis. Mr. Backes agreed with Dr. Kaufman in the belief that the Justices favor the proposed rule and are anxious to have the pilot study.

Dr. Greifinger emphasized that both proposals were studied because of criticism of doctors and the medical profession. The question of impartial medical witnesses has been under study for at least eight years. Each time the Society has offered a proposal it has been rejected by the lawyers. From a public relations standpoint, if this latest proposal fails, the courts—and the public, if need be—should be informed that the medical profession has tried to do something constructive and has consistently had its efforts thwarted by the opposition of attorneys. If the rules are not accepted, the medical profession should not be criticized for this inaction.

Dr. Blaisdell moved—seconded by Dr. Bowers, and carried—that the special committee prepare a summary of its findings and the sentiment of the Board of Trustees, and that the report be available for the next meeting of the Board.

COUNCIL ON MEDICAL SERVICES

Medical Care for Public Assistance Recipients: The State Department of Institutions and Agencies has asked for Medical Society assistance in evolving a state-wide medical care plan for public assistance recipients. This was assigned as a project to the Council on Medical Services by President McCall.

The project will entail implementation of recommendation 3 of the Commission to study Public Medical Care:

> "Utilization of a vendor payment system for all items of medical care."

Among the elements of such a plan would be:

1. An outline of the services to be provided;
2. A presentation of adequate medical care standards to apply; and
3. Details of vendor payment.

Representatives of the Division of Welfare present were:

Bertram M. Bernstein, M.D., Medical Director
Mr. Irving J. Engelman, Chief, Bureau of Assistance

The project was discussed for three hours, after which the following subcommittee was appointed to meet with Division representatives to draft a plan for report to and consideration by the council:

Raymond J. Germain, M.D., Chairman
Harry R. Brindle, M.D.
Irving Klompus, M.D.
F. Clyde Bowers, M.D., Consultant
Mr. Richard I. Nevin, Consultant

As soon as the final approved draft of the plan is ready, it will be submitted to the Board of Trustees.

Proposed Relative Value Index. In 1960 our House of Delegates directed that the proposed Relative Value Index be referred to the component societies for study and determination of the wishes of their members; the results of the study to be reported to the Board of Trustees by November 1, 1960; and the Board to present the results to the next meeting of the House of Delegates.

All component societies were officially notified of the above action of the House of Delegates. All component societies have been urged on several occasions to have a member of the Council on Medical Services present at a meeting to discuss the proposed Index. Actually, only nine of the 21 component societies have considered or scheduled its consideration.

The Executive Officer has offered, with the cooperation of the council, to prepare for distribution to the membership a series of questions most commonly raised by the members concerning the proposed Index, and the answers thereto.

The members of the Council on Medical Services reiterated their willingness to appear before any component society meeting to discuss the proposed Relative Value Index for New Jersey.

Upon motion by Dr. Allman—seconded by Dr. Greifinger, and carried—the progress report of the council was accepted.

Upon motion by Dr. Featherston—seconded by Dr. McCall, and carried—the Board went into *Executive Session* from 12:50 to 1:05 p.m.

Dr. Featherston proposed that at the next annual meeting recognition be made of Mr. Nevin's ten years of service as the Society's Executive Officer.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that, in recognition of Mr. Nevin's ten years of service as the Society's Executive Officer, the Trustees' annual dinner be in his honor, and that he be presented with a plaque at that time.

INTERN PROGRAM

The following resolution was read to the Board, and approved for introduction at the December 1960 session of the A.M.A. House of Delegates.

> Whereas, annually the number of graduates from American and Canadian medical schools falls far short of the number required to fill available internships in the hospitals of the United States, and
>
> Whereas, many hospitals are regularly not only unable to fill their quotas but find it difficult to obtain the services of even a limited number of interns who are graduates of American and Canadian schools, and
>
> Whereas, other hospitals seem not infrequently to have more interns than their needs justify, therefore be it
>
> Resolved, that the American Medical Association through its Council on Medical Education be requested to review and revise the present programs governing the approval of internships and the assignment of interns so that the available supply of intern graduates of American and Canadian schools may be more equitably distributed among the approved hospitals of the country, with more consistent consideration of the number of patients to be cared for, the needs of the hospitals, and their facilities to train physicians in the arts of medical practice.

FOREIGN MEDICAL GRADUATES

At its October 1960 meeting, our Board approved the recommendation of the Medical-Hospital Liaison Committee "that both parent state organizations take proper steps through their respective national organization to induce the Joint Commission to modify or to postpone the effective date of its ruling, in the interest of the care of patients in the hospitals of New Jersey."

The following resolution was presented by the Executive Officer for the Board's consideration:

> Whereas, there is a critical shortage of American trained interns in the hospitals of the nation, but especially in the Atlantic Coastal region, and
>
> Whereas, in consequence, many hospitals have come to rely in great part upon the services of interns who are graduates of foreign medical schools, and
>
> Whereas, an abrupt and substantial decrease in availability of such foreign medical school graduates would disorganize and imperil both the programs of intern training and of patient care in affected hospitals, therefore be it
>
> Resolved, that the House of Delegates of the American Medical Association recommend that the cut-off date (December 31, 1960) for graduates of foreign medical schools who have failed to pass the examination of the Educational Council for Foreign Medical Graduates be extended for a period of one year, to enable affected hospitals further time to achieve an adjustment in the area of their intern needs.

Mr. Nevin informed the Board that the Pennsylvania Medical Society is introducing a similar resolution, differing only in that they ask for a deferment of six months.

Dr. Costello reported that the AMA Board of Trustees has recommended to the Council on Medical Education and Hospitals that "judicious consideration be given to the local factors involved" in the enforcement of the December 31, 1960, cut-off date.

Dr. Weigel called attention to an item in the *New York Times*, under date of November 19, 1960, which reported that the AMA, under pressure from the State Department, had moved to grant a six months' reprieve to over 1900 foreign medical school graduates who had failed to qualify.

Dr. Allman moved—seconded by Dr. Wegryn, and carried—that the resolution be approved for introduction at the 1960 AMA Clinical Session.

DOCTORS OF OSTEOPATHY

The Executive Committee, at its meeting on November 3, 1960, requested the Executive Officer to prepare a resolution for introduction at the 1960 AMA Clinical Session asking the House of Delegates to resolve the conflict of direction concerning the association of doctors of medicine and doctors of osteopathy. Mr. Nevin presented the following resolution to the Board of Trustees for its consideration:

> Whereas, it is, and consistently has been, the ruling of the Judicial Council of the American Medical Association that under the Principles of Medical Ethics all voluntary professional association of doctors of medicine with doctors of osteopathy is prohibited, and
>
> Whereas, the Joint Commission on Accreditation of Hospitals, as of September 17, 1960, voted to survey for purposes of accreditation hospitals with osteopaths on their staffs, providing their work is under the general supervision of doctors of medicine, and
>
> Whereas, this action of the Joint Commission is in disregard of the Judicial Council's constitutional authority and leaves the average doctor of medicine confused as to what he is expected to do as regards professional association with doctors of osteopathy, therefore be it
>
> Resolved, that the House of Delegates of the American Medical Association take cognizance of the confusion of direction involved in these contradictory utterances and proceed forthwith to accomplish a clearcut and unequivocal delineation of the official and approved professional relationship that is to be maintained between doctors of medicine and doctors of osteopathy in all areas and aspects of professional action.

Dr. Kaufman moved—seconded by Dr. Greifinger, and carried—that the resolution be approved for introduction at the 1960 AMA Clinical Session.

FUTURE PHYSICIANS CLUB

A resolution from the Essex County Medical Society called for The Medical Society of New Jersey to request the AMA to recommend that all county medical societies consider taking leadership in maintaining a continued quality in the ranks of medicine by organizing local Future Physicians Clubs for the purpose of recruiting talented and dedicated students for medical careers; and request that the AMA adopt this as a national project.

Dr. Bedrick questioned the validity of the opening paragraph of the resolution which stated that ". . . the quality of applicants to

American Medical Colleges has declined in the past few years . . ." in view of the statistics reported in the November 14, 1960, JAMA. The report in the JAMA indicates that there has been little if any change in the "quality of applicants" during the past ten years.

Dr. Allman moved—seconded by Dr. Jehl, and carried—that the resolution be referred to the 1961 House of Delegates of The Medical Society of New Jersey for consideration and action.

BLOOD REPLACEMENT RESPONSIBILITY

The Board considered a resolution adopted by the Washington State Medical Association, calling upon the AMA to stand opposed to the payment for whole blood and red blood cells by pre-paid health programs—not to be construed as including opposition to the payment for the costs of cross matching, typing, administration of blood or by-products of blood.

Dr. Blaisdell moved—seconded by Dr. Allman, and carried—that the resolution be referred to the AMA Delegates for whatever action they deem appropriate.

SUPERVISION OF LABORATORY WORK

As requested by the Board of Trustees, the Council on Medical Services considered a resolution received from the Duval County Medical Society, Florida. This recorded the opposition of the Duval County Medical Society to the recommendation of the Joint Commission on Accreditation of Hospitals to the effect that, "only reports of clinical laboratory work done in laboratories *supervised by qualified clinical pathologists* should be accepted for hospital inpatients or out-patients. This should be the original report from the laboratory and properly authenticated, be placed in the patient's record."

The Duval County Medical Society recommends that "laboratory work attached to the clinical record *by the responsible staff doctor* be accepted at its face value" and that "safeguards be established and enforced against violations of the ethics and principles of this privilege."

The Council on Medical Services recommended that the Duval County Medical Society resolution be supported by The Medical Society of New Jersey, and that our A.M.A. Delegates be so instructed.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that the Duval County Medical Society resolution and the recommendation thereon from the Council on Medical Services be referred to the AMA Delegates for whatever action they deem appropriate.

ACCOLADE FOR DR. COSTELLO

The Trustees tendered a rising vote to Dr. Costello on his first appearance before the Board as Vice-President of the American Medical Association.

HONORARY MEMBERSHIP

In a communication from the chairman of the Committee on Honorary Membership, Dr. Crowe, it was reported that (in accordance with the Constitution, Article VII, Section 7) the committee has acted upon two nominations referred to it by the Board of Trustees. The committee approved the nominations of 1. Elmer L. Shaffer, Ph.D., Trenton, and 2. Selman A. Waksman, Ph.D., New Brunswick.

Upon motion by Dr. Lloyd—seconded by Dr. Jehl, and carried—the nominations of Dr. Shaffer and Dr. Waksman for election to Honorary Membership were approved by the Board of Trustees. The chairman directed that the nominations be transmitted to the component societies as required by the Constitution.

MEDICARE SUPPLEMENTAL AGREEMENT

A supplemental agreement to the Medicare contract, received from Washington, lists several non-controversial changes in the Joint Directive. The supplemental agreement has been reviewed and executed by Medical Service Administration of New Jersey, fiscal agent for the program, and it has the approval of the Committee on Medicare.

Dr. Ware moved—seconded by Dr. Allman, and carried—that the Board of Trustees authorize the proper officials to sign the supplemental agreement.

AUDIT REVIEW COMMITTEE

The special committee reviewed the "Report of Audit for the Fiscal Year ended May 31, 1960." Questions directed to the chairman of

the Committee on Finance and Budget, Dr. Allman, concerning bookkeeping policies, surplus funds, and transfer of funds to Medical Student Loan Fund were answered to the satisfaction of the committee. By unanimous action, the committee accepted the report of audit for 1959-60, as submitted by J. S. Teunon and Company under date of July 25, 1960.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that the report of the committee be accepted.

AMA ALTERNATE DELEGATE

Dr. Mulligan reported that Dr. Crowe, AMA Delegate, would be unable to attend the 1960 AMA Clinical Session in Washington due to illness, and that Dr. Crowe had returned his credential card for assignment to an alternate.

Dr. Wegryn moved—seconded by Dr. Allman, and carried—that Dr. Lance be appointed to serve for Dr. Crowe at the 1960 AMA Clinical Session.

The Board's attention was called to the fact that Dr. Crowe has been appointed as a member of the AMA Committee on Credentials, and it was suggested that the chairman of the AMA Credentials Committee be notified that Dr. Crowe will not attend the meeting in order that another appointment can be made. The Secretary was requested to telegraph the chairman of the AMA Credentials Committee and inform him that Dr. Crowe would not attend the meeting.

BOARD OF MEDICAL EXAMINERS

Dr. Mulligan informed the Board that Dr. Weigel's term as a member of the State Board of Medical Examiners would expire on December 23, 1960, and requested nominations for submission to the Governor.

Upon individual motions—whfch were seconded, and carried—the following nominations were approved in the order of preference indicated:

1. Elmer P. Weigel, M.D., Plainfield
2. Frank J. Hughes, M.D., Camden
3. Marcus H. Greifinger, M.D., Newark

SYMPOSIUM ON CONGENITAL DEFECTS

The Committee on Public Health of the Academy of Medicine of New Jersey is organizing a Symposium on Congenital Defects, to be held in Newark on April 19, 1961. The Medical Society is invited to co-sponsor the program with the Academy, the New Jersey Department of Health, and the National Foundation.

Dr. Allman moved—seconded by Dr. Bowers, and carried—that the Medical Society be a co-sponsor of the symposium.

MSP PREMIUMS

The Board authorized the president to report to MSP that the Trustees of The Medical Society of New Jersey favor an increase in MSP premium rates sufficient to replenish and stabilize the Plan reserves.

Help for Physicians' Widows

Do you know of any widow of a physician in serious financial need? Impoverished? In dire straits?

Assistance is available if her husband was a member of The Society for the Relief of Widows and Orphans of Medical Men of New Jersey, regardless of how long ago he died. Forever, during her lifetime, she has available the friendly concern, the helpful solicitude, and the financial resources of this society.

Immediate assistance is given the widow and children on a member's demise and even further assistance is available should it be needed. Some such widows have been helped for a considerable period following the loss of their husbands.

The Trustees of the Society fear that others, deserving and entitled to assistance, are being overlooked. Anyone who knows of a needy widow of a physician who might have been a member of this society, should notify the secretary, Joseph W. Gardam, M.D., 16 Longfellow Avenue, Newark 6, N. J., or the Treasurer, George F. Stoll, M.D., 330 Washington Avenue, Belleville 9, N. J.

Offices to be Filled by Election

1961 Annual Meeting

Office	*Term*	*From*		*To*		*Incumbent and County*
President-Elect	1 year	May	1961	May	1962	Ralph M. L. Buchanan, Warren
First Vice-President	1 year	May	1961	May	1962	Louis S. Wegryn, Union
Second Vice-President	1 year	May	1961	May	1962	Carl N. Ware, Cumberland
Secretary	1 year	May	1961	May	1962	Marcus H. Greifinger, Essex
Treasurer	1 year	May	1961	May	1962	Daniel F. Featherson, Monmouth
Trustees: (*—Second consecutive full term expiring; ineligible for re-election.)						
First District	3 years	May	1961	May	1964	Jerome G. Kaufman, Essex
Fourth District	3 years	May	1961	May	1964	*C. Byron Blaisdell, Monmouth
Fifth District	3 years	May	1961	May	1964	Louis K. Collins, Gloucester
Judicial Councilor:						
Third District	3 years	May	1961	May	1964	Charles H. Calvin, Middlesex
A.M.A. Delegates:						
	2 years	Jan.	1962	Dec.	1963	William F. Costello, Morris
	2 years	Jan.	1962	Dec.	1963	Aldrich C. Crowe, Cape May
A.M.A. Alternates:						
	2 years	Jan.	1962	Dec.	1963	Elton W. Lance, Union
	2 years	Jan.	1962	Dec.	1963	John L. Olpp, Bergen
Delegates and Alternates to Other States:						
New York:						
Delegate	1 year		For 1962 Convention			William F. Costello, Morris
Alternate	1 year		For 1962 Convention			Levi M. Walker, Atlantic
Connecticut:						
Delegate	1 year		For 1962 Convention			Lloyd A. Hamilton, Hunterdon
Alternate	1 year		For 1962 Convention			S. Eugene Dalton, Atlantic
Administrative Councils:						
Legislation:						
Third District	3 years	May	1961	May	1964	Leonard Rosenfeld, Hunterdon
Sixth Member	3 years	May	1961	May	1964	Sigmund C. Braunstein, Hudson
Medical Services:						
Third District	3 years	May	1961	May	1964	Durant K. Charleroy, Mercer
Sixth Member	3 years	May	1961	May	1964	Donald B. Hull, Bergen
Public Health:						
Third District	3 years	May	1961	May	1964	Elmer J. Elias, Mercer
Sixth Member	3 years	May	1961	May	1964	Pascal J. Baiocchi, Essex
Public Relations:						
Third District	3 years	May	1961	May	1964	Gerard R. Gessner, Middlesex
Sixth Member	3 years	May	1961	May	1964	William P. Mulford, Burlington
Standing Committees:						
Annual Meeting	3 years	May	1961	May	1964	Peter H. Marvel, Atlantic
Finance and Budget (from House of Delegates)						
	3 years	May	1961	May	1964	Francis A. Hauck, Cape May
Medical Defense and Insurance						
	3 years	May	1961	May	1964	Daniel F. Featherston, Monmouth
Medical Education						
	3 years	May	1961	May	1964	Malcolm M. Dunham, Middlesex
Publication						
	3 years	May	1961	May	1964	C. Spencer Davison, Salem
	2 years	May	1961	May	1963	Frank L. Rosen, Essex
(Dr. Rosen appointed by Board of Trustees, 6/60, to fill 1 year of unexpired term of Dr. Joseph E. Mott, deceased)						
Woman's Auxiliary Advisory						
	3 years	May	1961	May	1964	A. Guy Campo, Gloucester

1961-62 MEMBERSHIP DIRECTORY

Is Your Listing Correct?

The 5th Edition of the biennial Membership Directory is scheduled for publication and distribution in the summer of 1961.

Make sure your listing is accurate and complete by checking your current listing and submitting any changes and/or additions PROMPTLY — in printed form—to the:

MEMBERSHIP DIRECTORY DEPARTMENT
THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, N. J.

Chemotherapy in Tuberculosis

Minimum standards of chemotherapy in tuberculosis (defined at the 1960 Princeton Conference) are available from the New Jersey Tuberculosis and Health Association. These were developed at a meeting co-sponsored by the state tuberculosis association, by The Medical Society of New Jersey, and by the State Department of Health.

Stimulated by this conference, the State of New Jersey authorized immediate funds for the distribution of anti-tuberculosis drugs.

The conference was a follow-up on the basic recommendation of the Arden House Conference on Tuberculosis. It set for itself two goals: recommendations for minimum standards in chemotherapy, and recommendations for availability of drugs. These recommendations are of particular interest to New Jersey's private physicians, who are carrying an increasing load in the treatment of tuberculosis.

MINIMUM STANDARDS OF CHEMOTHERAPY

Isoniazid should be in every drug regime. For children the dose is 10 to 15 milligrams per kilo of body weight. For an adult weighing less than 60 kilograms, the dose is 300 milligrams a day. For heavier adults, the dose is 5 to 8 milligrams per kilogram of body weight.

PAS should be the routine companion drug. Dose approximates 12 Grams a day.

Streptomycin is used in special cases in place of PAS. Best results are obtained only if streptomycin as well as isoniazid are given daily. Intermittent (b.i.w.) use of streptomycin invites the development of resistance. Dose of streptomycin is a Gram a day, every day.

Toxicity: The physician will familiarize himself with toxic reactions which might result from drugs. Drugs should not be stopped because of mild to moderate side effects, but should be continued at temporarily reduced dosage, perhaps with adjunctive drugs. Gastric irritation *per se* is no reason for stopping PAS therapy.

Minimum *duration of therapy* with combined drugs should be two years. And recent tuberculin reactors (those converted within a twelvemonth period) should be treated for one year with isoniazid.

Children through age 4 who are positive tuberculin reactors should be treated. Beyond age 4, many (certain adolescents and pregnant women) may require prophylactic INH; these individual problems are best handled after consultation.

In cases of *drug failures and relapses,* other drugs may be used. Such special cases are best handled in hospitals where these drugs and surgical measures are available. All of

these other drugs have greater toxicity and require closer supervision.

For *open negative cases*, no specific recommendation is made other than the statement that special treatment may be indicated when a cavity remains open after two years of drug treatment.

CONDUCT OF TREATMENT

Treatment for all active cases of tuberculosis should be started in a sanatorium or in a pulmonary disease hospital if at all feasible. Ask for a thorough bacteriologic evaluation and a tuberculin test. If bacteriologic studies cannot be made, a tuberculin test should certainly be done. Treatment should not be started unless the tuberculin test is positive. Other diagnostic measures are indicated if the tuberculin test is negative.

No routine recommendation is made for pre-treatment susceptibility studies. If positive cultures continue to be obtained during treatment, susceptibility studies should be obtained *at least every few months.*

Obtain tracheal lavage specimens or gastric washings in patients who no longer expectorate adequate amounts of sputum.

After completion of the prescribed course of therapy, the patient should be followed by x-ray every three months for five years. Thereafter, such persons should be followed at least yearly.

Vacinnia Immune Globulin

A program for the preparation and distribution of vaccinia immune globulin (VIG) has been established by the American National Red Cross in cooperation with the Armed Forces of the United States. This hyperimmune gamma globulin is prepared from blood provided by the Armed Forces from recently vaccinated servicemen. It contains a high titer of antibodies effective in arresting abnormal infections with vaccinia virus, the agent used in vaccination to produce immunity to the related but dangerous virus of smallpox.

The importance of universal vaccination against smallpox has been demonstrated repeatedly. Thousands of cases occur in parts of the world in which precautions against the disease are inadequate. This universal vaccination is more important than ever because of the increase in rapid world-wide transportation.

There are two situations related to smallpox prevention in which something more than vaccination is needed. The first is a known exposure to smallpox where an added boost of immunity is needed. The second is the rare complication from the vaccination itself. These situations represent medical emergencies in which adequate treatment must be given as early as possible. VIG has been developed to give the physician a specific means of managing these conditions.

The American National Red Cross has a program for the distribution of sufficient VIG to meet the needs of the country. Since the scant supply of this rare blood fraction could be dissipated if it were used when not indicated, seven physicians on the staffs of prominent medical colleges throughout the country have been appointed as consultants to assist in distribution. Any physician who feels that VIG might be required for a patient should telephone the nearest consultant.* If it is agreed that the patient will benefit from VIG, the consultant will authorize shipment from the nearest regional blood center. Regional blood centers have a 24-hour coverage and are equipped to arrange immediate transportation to the attending physician.

In recent years the Red Cross has assisted Dr. C. Henry Kempe, professor of pediatrics at the University of Colorado, in a large-scale research program. His studies and those of other investigators show that VIG is *not* indicated in (1) cases which are not vaccinia, such as chickenpox, herpes zoster, etc.; (2) normal vaccinations which are disturbing because of febrile reaction, pain and swelling with normal primary "takes"; and (3) trivial secondary inoculations on non-vital areas of the body. VIG *is* effective in preventing the disease or diminishing the severity of smallpox in individuals who have had close contact with a case of smallpox. It is highly effective in the treatment of the rare complications from vaccination, the most frequent of which is accidental inoculation into the eye resulting from

*Either Dr. H. F. Eichenwald, 525 East 68 St., New York (phone: extension 7428 at Trafalgar 9-9000); or Dr. Henry Shinefield, at Hawthorne (N.J.) 7-7127.

a child touching the vaccination and then putting his finger in his eye. Early treatment with VIG will result in a marked improvement within hours and prevent possible loss of vision. Special care should be taken in vaccinating children if they have brothers or sisters with eczema because of the likelihood that they might develop vaccinia lesions on their affected skin areas, "eczema vaccinatum." Before VIG was available this condition carried a high mortality rate, but now adequate treatment arrests the disease. Very rare individuals lack the normal body defenses against infection and may develop such serious conditions as generalized vacinnia or vaccinia necrosum; VIG is the only specific treatment for these conditions.

A report form will accompany each shipment of VIG, and the physician is requested to complete and return it to the Research Director, Blood Program, American National Red Cross Headquarters, Washington 6, D. C.

Obituaries • • •

DR. ALFONSE L. CANTELMO

Dr. Alfonse L. Cantelmo died on New Year's Eve of a heart attack. He was only 48 years old at the time, and was an attending gynecologist at the East Orange General Hospital. Born in Newark in 1912, he was graduated from Hahnemann in 1939. Dr. Cantelmo interned at East Orange General in 1939-40. He was also on the surgical staff at Clara Maass, and was active in the affairs of the Essex County Medical Society. He was a Fellow of the American Academy of Obstetricians, Gynecologists and Abdominal Surgeons. He had been a vice-president of his county medical society and a soloist with its well-known Medical Choral Society. He was a Fellow of the International College of Surgeons.

DR. C. COULTER CHARLTON

On January 9, death came to Dr. C. Coulter Charlton, a retired Atlantic County otolaryngologist. Born in 1887, Dr. Charlton was graduated from the medical school of the University of Louisville. After a period of general practice, he was commissioned in 1917 in the medical corps of the U. S. Army and saw active duty during all of World War II. He then did graduate work in otology and laryngology and settled in Atlantic City. He became affiliated with the Atlantic City Hospital, and passed through all grades, eventually becoming chief of the eye-nose-throat service there. Dr. Charlton was an FACS and also active in the affairs of the American Laryngological Society.

DR. JOSEPH A. CLARKEN

Dr. Joseph A. Clarken, one of Newark's pioneer otolaryngologists, died of a coronary attack suddenly on December 28, 1960. Born in Paterson in 1894, Dr. Clarken was graduated from the medical school of the University of Maryland in 1920. After interning in Mercy Hospital in Baltimore he came to Newark and associated himself with the late Henry C. Barkhorn. Three years later he established his own office for the private practice of otolaryngology and became affiliated with many hospitals in Essex County. At the time of his death, he was a chief at both St. Michael's and Eye and Ear Infirmary and had staff appointments at Presbyterian, St. James and Soho. During World War II, he headed up the Emergency Medical Service of the Newark Defense Council.

DR. DAVID CORN

A past-president of the Bergen County Medical Society, Dr. David Corn died in Florida on December 25, 1960. Born in 1882, he was graduated in 1907 from Bellevue, and moved to New Jersey to accept an internship at the Hackensack Hospital. Only last year, Dr. Corn was hailed as the oldest living ex-intern of the Hackensack Hospital. He liked Bergen County, and made his home there, practicing in Teaneck and Ridgefield Park. Dr. Corn served the people of northern New Jersey for a half century. Becoming increasingly interested in gynecologic surgery, he did graduate work in that field in Vienna and then devoted his practice to that specialty. He passed through all grades in gynecology at the Hackensack Hospital, even-

tually becoming head of that service. Dr. Corn was active in religious and civic affairs. He was the first president of the Ridgefield Park Hebrew Association, and a founder of the Bergen County YMHA. He was also a Fellow of the American College of Surgeons.

DR. THOMAS R. D'ADDARIO

At the untimely age of 51, a cerebral hemorrhage took the life of Dr. Anthony D'Addario of Glen Ridge on December 19, 1960. Born in Italy, he was taken to the United States in infancy and in 1936 received his M.D. degree at the University of Chicago. After winning a coveted Cooks County Hospital internship, Dr. D'Addario came to Newark and practiced here from 1937 to 1942, when he entered the Army. He became regimental surgeon for the 100th Division and was awarded a Bronze Star. On being demobilized he returned to New Jersey, taking up his residence in Glen Ridge but maintaining his office in north Newark. He served the Presbyterian, the Columbus and the Clara Maass hospitals. Dr. D'Addario was a general practitioner and often said that he was proud of that title.

DR. JOSEPH F. DeCOTIIS

Word has just been received of the death on August 11, 1960, of Dr. Joseph F. DeCotiis, a member of the Bergen County Medical Society since September 1954. Dr. DeCotiis had, on June 30, 1960, completed a three-year residency in psychiatry at the State Hospital, Norristown, Penna. He had returned to practice psychiatry in the Ridgewood-Paterson area.

Dr. DeCotiis received his medical degree from Georgetown in 1953. He was born in 1926 and his death last summer at the age of 34 is one of the youngest to be recorded in our annals.

DR. WARREN J. DUCKETT

One of New Jersey's oldest practitioners died on December 11, 1960 with the death that day of Dr. Warren J. Duckett. Dr. Duckett was born in 1879 and in 1904 received his M.D. degree at Columbia University. A native of upper New York State, he came to New Jersey to intern at the St. Francis Hospital in Jersey City, and—liking what he saw in our state—he elected to remain here. For 50 years he did general practice as the traditional family doctor. In his earlier days, he was active in the affairs of the Hudson County Medical Society and was affiliated with Christ Hospital in Jersey City. In 1953, at the age of 74, he retired and made his home in Asbury Park.

DR. ROBERT E. HALDEMAN

Death came on December 1, 1960 to Dr. Robert E. Haldeman, a well known Burlington County general practitioner. Dr. Haldeman, formerly, and for many years, coronor's physician there, was 61 at the time of his death from a coronary attack. Some years ago, he was president of our Burlington County Component Society. He was active in the affairs of the medical staff of the Burlington County Hospital and also in the work of the County Medical Society.

DR. THOMAS F. HIGGINS, JR.

Union County lost one of its most active physicians on December 22, 1960 when Dr. Thomas F. Higgins, Jr., died of pulmonary edema following a fractured leg sustained in a hit-and-run automobile accident a few days before. Dr. Higgins received his M.D. degree in 1937 at Georgetown University and returned to his native city to intern at the Elizabeth General Hospital. At the conclusion of his internship in 1938, he entered private practice, serving for two years as surgeon to the New Jersey Central Railroad. Then, in 1940, he was commissioned in the Army and remained on active duty throught most of the war. He won distinction in 1943 when he crawled into a wrecked and burning airplane to rescue the trapped crew. On return to private practice at the war's end, he became Elizabeth Police Surgeon. He became associated with the Alexian Brothers and the Elizabeth General Hospitals, and was active in the affairs of the Union County Medical Society.

DR. HERBERT H. STRAUB

Death came on December 15, 1960 to Dr. Herbert H. Straub, a general practitioner of the Oranges. Dr. Straub was graduated in 1911 from the medical school of Cornell University. He was a much beloved family doctor from the time he opened his office in 1912 until his retirement in 1958. He was affiliated with Clara Maass and East Orange General Hospitals. Dr. Staub was born in Long Island in 1888, and interned at the Methodist Episcopal Hospital in Brooklyn.

Announcements

Nutrition Seminar

Philadelphia has been chosen as the site for a series of free lectures and colloquia on clinical aspects of nutrition. Meetings are held at 8 p.m. Wednesdays, January 18, February and March 15, April 19, May 10 and June 7. All aspects of metabolism will be covered. For details write to Dr. Michael Wohl, County Medical Society, 1727 Pine Street, Philadelphia 3, Penna.

Oral and Metabolic Symposium

The Medical Center in Jersey City has been selected as the site for the colloquium on Oral and Metabolic Diseases, Wednesday afternoon, March 22. Sponsored jointly by our State Health Department and the State Dental Society, the program includes papers on (1) The interrelationship between oral and systemic disease; (2) Dental problems of the diabetic; (3) Oral manifestations of nutritional disorders; as well as a panel discussion on the interrelationships between the two professions (medicine and dentistry) in this field. Detailed program may be obtained from Dr. Albin Rauch, 551 South Orange Avenue, South Orange.

Pediatric Oncology

An intensive course in pediatric oncology for general practitioners and pediatricians will be held April 26, 27 and 28 at the Memorial Hospital in New York City. Limited to 15 physicians, this intensive practical seminar will cover all aspects of diagnosis and management of tumors and related disorders in childhood. The fee is $35.

For further information write to Memorial Hospital, 444 East 68th Street, New York 21, N. Y.

Medical Tour of Israel

A medical tour of Israel constituting a graduate program will be offered by the University of California, from April 20 to May 15. This is part of an effort toward international cooperation in medicine. Sessions were planned in cooperation with the Hebrew University School of Medicine in Jerusalem, and the Hashomer Hospital in Tel-Aviv.

Opportunities will be provided to observe the rapid development of medical care in Israel and to become acquainted with staffs of several medical institutions. Outstanding physicians will discuss management of tropical diseases as well as more common problems in internal and tropical medicine. Patients will be demonstrated.

Participants will go by air. Stopovers have been provided in Paris, Istanbul, Athens and Rome. Sightseeing trips to the major points of interest in each area have been arranged.

Inquiries concerning the Israel tour are addressed to: Dean of Continuing Education in Medicine, UCLA Medical Center, Los Angeles 24, California.

Pediatric Surgery

A symposium on pediatric surgery will be held at the New York University Medical Center, 550 First Avenue, New York City, from May 4 through 6, 1961. This colloquium will present the latest methods of diagnosis and management of surgical conditions in the newborn and older children. The program will interest the pediatrician, the surgeon and the general practitioner. A star-studded faculty has been assembled. One unique feature of the program will be the famous exhibit on neo-natal intestinal obstruction prepared by Dr. J. W. Hope.

Tuition for the 3-day meeting is $75. For further details, write to The Dean, Graduate School of Medicine, 550 First Avenue, New York 16, N. Y.

Graduate Program in Newton

Every Tuesday night beginning March 7 and terminating April 25, there will be a presentation at the Memorial Hospital, Newton, New Jersey on common problems in general practice. This is sponsored jointly by the Morris, Passaic, Sussex, and Warren County Medical Societies and is acceptable for 12 credit hours by the American Academy of General Practice. The total fee is $10 for the entire series of six meetings. The lectures start at 8 p.m.

For registration and further details write to Dr. Robert A. Weinstein, c/o Newton Memorial Hospital, Newton, New Jersey.

International Allergy Congress in New York

The next International Allergy Congress will be held in New York City, October 15 through 20, 1961. Papers read in other languages will be simultaneously translated into English. The program will draw allergists from all over the world, and an exceptionally "practical" curriculum has been developed for medical practitioners. There are still some program vacancies for physicians wishing to present material. Further details may be obtained from Dr. William B. Sherman, 60 East 58 Street, New York 22, N. Y.

Cuban Physicians Aided

The American College of Chest Physicians has established an Assistance Fund for Cuban chest physicians who have been exiled from their country. Additional contributions are welcomed. Those wishing to aid in this program may do so by writing to Dr. Murray Kornfeld at 112 East Chestnut Street, Chicago (11) Illinois.

Influenza Re-Immunization

Readers last month received a communication from our State Health Department dealing with influenza immunization. Commissioner Kandle has recently sent this JOURNAL a letter on the subject. The material parts of Dr. Kandle's letter follow:

"Labels on commercial vaccine now on the market, recommend a second dose of vaccine two weeks following the initial dose. The dosage schedule recommended in our letter and by the Public Health Service, calls for the administration of influenza vaccine on two occasions *separated by two or more months.*

The interval of two or more *months* between doses for adult immunization rather than the previously recommended interval of two or more *weeks* is specifically recommended by the Public Health Service Advisory Committee on Influenza. Investigations have demonstrated that a booster response from a second dose of vaccine *is significantly greater with the longer interval.* In the event of a threatened epidemic the two or more weeks' interval might again be expedient."

ROSCOE P. KANDLE, M.D.
State Commissioner of Health

For Your Traveling Patients

A good 5-cent investment, for yourself or for a traveling patient, is the leaflet, *Health Information for Travel in Europe.* Published by the U.S.P.H.S., this brochure tells you (and the patient) what vaccinations and immunizations are desirable or required for European travelers. It also gives dosages and brief data on how to get and use vaccination certificates and concludes with several practical health pointers. If many of your patients go to Europe, you can buy this leaflet at $3.75 a hundred (or in lesser quantities at 5 cents each) by writing to Superintendent of Documents, Washington 25, D.C. and asking for leaflet PHS-748 (Travel in Europe). If you want to splurge and invest 30 cents you can get a fat booklet that spells out, country by country, the immunization requirements for all the nations in the world. This one is called *Immunization Information for International Travel* and you get it by sending 30 cents to the Superintendent of Documents, Washington 25, D.C. and asking for it by that title.

County Society Reports • • •

Burlington

The *Burlington County Medical Society* convened in regular session on December 8, 1960, at Millside Farms, Riverside. President Boudwin called the meeting to order at 8:45 p.m. with 50 members and two guests in attendance.

Under the direction of the Public Relations Committee, a panel discussion on "The Doctor and The Press" had been arranged, with Mr. Chester L. Reagan moderating for the panel of two physicians and two newspaper editors. Dr. Perry S. MacNeal and Dr. Joseph Hughes spoke for the physicians and Miss Jane A. Stretch and Mr. Gregory Hewlett, editors of the *Camden Courier Post* and the *Maplewood News-Record,* respectively, represented the press. This was a most timely and interesting presentation. Several honest differences of opinion were expressed concerning anonymity of physicians, newsworthiness of stories about illnesses of prominent individuals, the value of popular medical articles in magazines, and similar problems. It was emphasized that the press can be a link between physicians and the public to help establish better understanding.

Dr. Joseph H. Kuder presented a Memorial Resolution on Robert Edison Haldeman, M.D., our immediate past president who died December 2. The Resolution was adopted and ordered spread upon the minutes. A copy will be sent to the bereaved survivors as a gesture of our sympathy and respect.

The proposed "Pilot Plan for Eye Care on Funded Payment Basis," was then brought up for discussion. This plan had been disapproved by the Executive Committee at its meeting November 20. On a motion unanimously adopted, our Society accepted the recommendation of the Executive Committee that the plan be disapproved.

President Boudwin administered membership oaths to Drs. Brachfeld, Goldfield, Saltzman, Pawluk and Stein, who had been voted into membership previously.

No further business, the meeting adjourned at 11:30 p.m.

EDWARD D. WILDMAN, M.D.

Reporter

Camden

The second general meeting of the *Camden County Medical Society* for this season convened at 9:05 p.m. on January 4 at the Cherry Hill Inn, and was called to order by President Ornaf. Seventy-six members were in attendance.

Drs. Howard F. Shivers, Jr., Nicholas Karayannis, John R. McDermit, Robert Lesher, Norman N. Kohn, Ludwig E. Schlitt, Leo L. Sell and N. Malcolm Balotin were sworn in and introduced.

Dr. Palmer then presented Mrs. Herr, Director of the Camden County Nutrition Consultation Service. Mrs. Herr spoke on the service that her office renders in connection with special diets. She discussed the relative nutritional value of foods.

Dr. Ornaf introduced Dr. Most who presented Dr. Luis Fernandez-Herlihy of the Lahey Clinic. Dr. Fernandez-Herlihy spoke about the collagen diseases listing rheumatoid arthritis, disseminated lupus erythematosus, dermatomyositis, scleroderma, and periarteritis nodosa, as the five disorders included in this classification. He discussed the symptoms, early diagnosis and treatment of these diseases and responded to questions.

Dr. Ornaf reviewed the progress being made by the Emergency Coverage Committee and the Indoctrination Program. He explained the Relative Value Index, outlining the discussion which had occurred in the Executive Committee on this subject.

Dr. Harold Eynon, chairman of the Insurance Committee, spoke of the new professional liability insurance program offered through The Medical Society of New Jersey. Dr. Eynon then introduced Dr. Daniel Featherston, chairman of the State Society's Insurance Committee. Dr. Featherston explained the circumstances leading to the formulation of this program, stating that members had been inadequately covered and that in at least one county, osteopaths, veterinarians and beauticians had been grouped together with medical doctors as a professional group. Dr. Featherston stated that policies held under this program would not be cancelled without consultation with the Society, but that the premium could definitely *not* be guaranteed at a lower rate than that offered by competing companies. The premium would be at the prevailing rate. Other companies were cancelling liability insurance because they were unable to realize a profit from such a program. Dr. Featherston saw no advantage in using a local broker. He felt that frequently local brokers were insisting on broad insurance coverage in addition to malpractice insurance. Mr. Joseph A. Britton, a representative of the American Mutual Liability Insurance Company, then discussed the manner in which such a policy might be obtained.

Dr. Ornaf then reviewed the proposed "Pilot Plan for Eye Care on Funded Payment." This plan had been rejected by the ophthalmologists. Dr. Kline explained that it had been offered as a means by which unions could determine which ophthalmologists would examine their members rather than the members determining for themselves. Dr. Kline moved that this "pilot plan" be rejected and that a resolution be sent to the State Society stating our objection to the plan and giving an alternative plan. This passed unanimously.

FREDERICK W. DURHAM, M.D.

Reporter

Cumberland

Desplte the traffic-crippling weather, there were 24 members present when the December meeting of the *Cumberland County Medical Society* was held at the Holly House, Millville, at 2:30 p.m. December 13, 1960 with Alfred O. Davies, M.D., of Millville presiding.

The County Society approved the nomination of Elmer L. Shaffer, Ph.D., of Trenton, N. J., and Selig H. Waksman, Ph.D., of New Brunswick, N. J., for honorary membership in The Medical Society of New Jersey.

Dr. Shaffer has a long record of meritorious service in the U. S. Health Service and the N. J. Society of Clinical Pathology. He is the Director of the N. J. Laboratory of the N. J. State Board of Health.

Dr. Waksman was a Nobel Prize winner in 1952 in Physiology and Medicine; Co-discoverer of streptomycin and discoverer of other antibiotics, including streptocin, neomycin and condicidin, and he is an outstanding Enzymologist in soil chemistry and among other things, author of some 350 scientific papers.

The following areas were highlighted in a report from Public Relations Chairman, Kurt Hanson, M.D., of Millville:

(1) Reaffirmation of the profession's interest in emergency service, emphasizing the fact that the service isn't only to save life but it is to serve the public.

(2) The need of youth to enter the profession of medicine and its allied fields. Dr. Hanson indicated that one group has organized chapters of Future Physicians Clubs.

Dr. Harry A. Reinhart of Millville, president-elect, gave a dissertation on modern technics of diagnostic radiologic procedures, which may be used in suburban as well as in urban hospitals. Dr. Reinhart reviewed the historical development of radiology from the discovery of x-rays until the present. He pointed out that fluoroscopy, because of undue exposure to the patient, is being supplanted by serial x-ray, thus eliminating heavy dosage of roentgen ray to the patient.

Recent procedures such as bronchogram, hysterogram, soft tissue examination of the breast for cancer, mammogram, saliogram, stereoscopic x-ray, venograms, anteriograms, and myelograms, were described in detail.

The meeting adjourned for a smorgasbord dinner.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding, the regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on December 6, 1960.

The speaker of the evening was Dr. Lester Blum, Associate Clinical Professor of Surgery, NYU Postgraduate Medical School, and Attending Surgeon at Downtown Beekman Hospital. Dr. Blum's subject was "The Acutely Ischemic Extremity." Many members participated in a discussion from the floor.

New members elected at the November meeting were introduced to the Society on this occasion.

Following the business meeting, a collation was served.

With Dr. Charles A. Landshof in the chair, the regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center, on January 3, 1961.

Speaker of the evening was Dr. Donald B. Hull, of the Committee on Medical Services, The Medical Society of New Jersey. Dr. Hull's topic was "The Proposed New Jersey Relative Value Index." Many members joined in a lively discussion on this important, practical and controversial subject.

Dr. Thomas M. Gocke, of the Seton Hall College of Medicine and Dentistry, was elected to regular Active membership in the Society.

Following the business meeting a collation was served.

LOUIS KOSMINSKY, M.D.

Reporter

Passaic

The regular monthly meeting of *The Passaic County Medical Society* was held on November 15, 1960 at 9:00 p.m. at the Valley View Hospital. Dr. F. Albert Graeter, the president, called the meeting to order and introduced Dr. Weintraub, who welcomed the members on behalf of the Board of Freeholders of Passaic County and the Board of Managers of Valley View Hospital.

The following were elected to Associate membership: Vincenzo Abate, Abe D. Stutchin, Arganey L. Lucas, Jr. of Paterson, and Eugene Bradley of Oakland.

The president called upon Dr. Peter G. Berkhout, Chairman of the Medical Practice Committee. Dr. Berkhout reported that the Welfare Council had approved a campaign for immunization against influenza and tetanus, and that doctors should do everything possible, through the media of mass communication, to educate and enlighten the public on the necessity of these inoculations. A committee will be appointed to organize the campaign for these immunizations.

Dr. Graeter then introduced Dr. Edward Wolfson, Program Chairman, who turned the meeting over to Dr. John Sarokhan. Dr. Sarokhan presented the guest speakers, Ernest L. Wynder, M.D., Head of Epidemiology, Memorial Hospital, New York, and Robert C. Hockett, Ph.D., of the Tobacco Industry Research Committee. They discussed the relationship of cigaret smoking to cancer of the lung. A question and answer period followed.

The program was exceptionally interesting and was enthusiastically received by the more than 125 members attending the meeting. Following the program, a delicious steak dinner was served by the Passaic County Valley View Hospital.

IRVING CHRISMAN, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held at the DuPont Penns Grove Country Club on December 16, 1960. Dr. Ford C. Spangler, President, presided. Several committees of the Society reported on their activities over the past month.

Dr. Warren Nichols of the South Jersey Research Foundation reported on his studies in *Chromosone Defects in Human Disease*. Dr. Nichols demonstrated several examples and discussed the use of this study both in research and diagnosis.

Following Dr. Nichols' presentation, Dr. Louis L. Coriell spoke about the activities of the Research Foundation. Dr. Coriell remarked upon the marked decrease in the number of poliomyelitis cases treated. He also compared the effect of live vaccine with Salk vaccine results.

The current recommendations for Salk vaccine are stated to be a cubic centimeter a month for three basic doses. A fourth dose is suggested at age one year and a fifth dose at age two years. Thereafter one cubic centimeter is recommended every two years until age 12; then a cubic centimeter every four years. Dr Nichols discussed the use of measles vaccine which, he said, looked promising when it is ready for commercial use.

At the present 28 people are working at the South Jersey Research Foundation. Some of the studies being conducted at this time concern the etiology of leukemia, rheumatic fever in monkeys, juvenile arthritis, the virus studies in bovine leukemia, bovine tissue cultures and low temperature storage of human tissues. The Foundation is in the process of establishing a Tissue Culture Cell Bank and Registry. Dr. Coriell said that the Research Foundation expects to have 40 workers on its staff within a year.

After lively discussion, the meeting was adjourned.

F. W. WINTERS, M.D.

Reporter

Union

The *Union County Medical Society* held its regular meeting at White Laboratories, Kenilworth, on September 14, 1960. The session was called to order by the President, Carl G. Kapp, M.D., at 8:30 p.m.

The following were elected to membership: Associate—Drs. Thomas Bradley, Harold C. Hardenburg, Bohdan R. Kusma, Evalina D. LiSooey, Erich V. Mueller, Grace L. Tarrant, Angelos L. Paraskevas; and Emilie V. C. Chang (elected by transfer from the Monmouth County Medical Society).

Dr. Coe, chairman of the Medical Insurance Committee, gave a report of a conference with the American Liability Insurance Company and representatives of other county societies.

Dr. Joseph Gannon spoke on the proposed New Jersey Relative Value Index. It was agreed that at some future meeting a discussion would be held with two members for and two members against the proposal.

Following the business meeting, a collation was served.

The Society held a regular session at White Laboratories, Kenilworth, on November 9, 1960. The meeting was called to order by the President, Carl G. Kapp, M.D., at 8:30 p.m.

Dr. Deutsch read the resolution on the death of Dr. Charles G. Darlington.

Dr. Schlein, Chairman of the Program Committee, introduced the speaker of the evening, Dr. Kenneth B. Babcock, Director of the Joint Commission on Accreditation of Hospitals. Dr. Babcock gave an informative talk on what the Commission looks for when it goes into a hospital, the importance of committees and how they can work for the benefit of the hospital and its staff. There was a question and answer period during which Dr. Babcock answered queries about autopsies, General Practice Sections, keeping of records and foreign graduates.

Dr. Erdman, Chairman of the Blood Bank Committee, reported on the recommendation of the Blood Bank Committee concerning the plan for a mobile unit suggested by the New York Regional Blood Program. The Society approved the recommendation.

The following were elected to membership: Associate—Drs. Frederick R. Carracino, John H. Cooper, Joseph D. Kovacs, A. Johan Noordsij, Frederick Palmieri, Jr., Christian Van Den Heuvel, John T. Gianis and Edmund A. Foster (transfer from the Mercer County Medical Society); Active membership—Drs. James L. Brady; Joseph I. Boylan (transfer from the Essex County Medical Society); Nancy A. Durant (transfer from the Norfolk County, Massachusetts, Medical Society); Leonard J. Thalheimer (transfer from the Hudson County Medical Society) and George Ladas (transfer from the Essex County Medical Society). From Associate to Active membership: Drs. Filippo DiSanto, Martin D. Liemer, Aurelio Romeo and Ralph Witmer, Jr.

Dr. A. D. Kovacs, Chairman of the Advisory Committee to the Woman's Auxiliary, reported on the meeting of the Indoctrination Committee held last week.

Following the business meeting, a collation was served.

HENRY J. MINEUR, M.D.

Reporter

Society for the Relief of the Widows and Orphans

At its November 23, 1960 session, the Trustees of the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey authorized payments to widows of former members who need further financial assistance. Some of these beneficiaries have been helped for several years. Christmas presents and quarterly payments during 1961 have been voted for several needy widows on our list.

The present state of this 78-year old Society can be briefly reported thus: It has *more* members and pays *greater benefits* now than ever before. The value of the Permanent Fund, the income of which is used only for the benefit of members' survivors, amounts to about $110,000.

If you know a needy widow or orphan children of a member of this Society please notify the secretary. Any medical man of this state is welcome to become a member. Application blanks are available.

J. W. GARDAM, M.D.

Secretary

Book Reviews • • •

Biochemistry of Human Genetics. A Ciba Foundation Symposium, jointly with the International Union of Biologic Sciences. G. E. W. Wolstenholme, Cecilia M. O'Connor. Boston 1960. Little Brown & Co. Pp. 347, illus. ($9.50)

This volume constitutes a report of the meeting held in Naples, Italy, during May 1959, attended by scientists interested in biochemistry and genetics. The topics discussed included hereditary galactocemia, cholinesterase, primaquine sensitivity of the erythrocytes, abnormal hemoglobins, haptoglobins, transferrins and hereditary gamma globulin, as well as an approach by tissue culture to some of these problems.

The first section of the book is devoted largely to problems of genetic control of metabolism. The second section reviews the synthesis of proteins and other macromolecules. In a third section, basic facts relevant to the mechanism of gene action are discussed.

Some of the chapters are followed by excellent discussions and other chapters throughout the volume are followed by a very concise summary. There is both an author and subject index at the end of the volume.

Certain statements appear to the reviewer to be open to question such as: "The presence of a characteristic limited to certain individuals in the population and to one racial group suggests genetic origin of that characteristic." However, we were not so favorably impressed with the attempts to relate drug-induced hemolytic anemias, favism and the discovery of the biochemical aspects of primaquine sensitive erythrocytes as hereditary constitutional factors on a recessive character basis. Perhaps our antagonism is based on the admitted newness of the concepts. More work along these lines and in the field of biochemical genetics is essential.

The volume should appeal to those working in research, genetics and to biochemists who have an interest in this field. The overall report is factual and certainly a desirable compilation, for which the Ciba Foundation is to be congratulated.

THOMAS K. RATHMELL, M.D.

Behavior Disorders in Children. Harry Bakwin, M.D. and Ruth M. Bakwin, M.D. Philadelphia 1960. Saunders. Ed. 2. Pp. 597. ($11.00)

The behavioral sciences have not reached the knowledgeable stage characteristic of the physical sciences. A loud "bravo" is due the Bakwins for a painstaking effort to bring to pediatricians a discussion of every phase and facet of the psychologic care of children. Every stone was turned to seek the newest facts and opinions of the experts in the field. The authors have distilled the essence. This is a concise, yet somehow, encyclopedic book. It is logically sequential starting with the growth and development of the child from the fetus on. The text covers the psychologic care and training of infants and children. There is an excellent treatise on the nursery school and another on adolescence. The pages devoted to discipline are a distillation of all the pamphlets and tomes ever written on the subject. The book even includes such rarely discussed subjects as: care of the physically ill and handicapped child; hospital care; blindness; deafness; organic disturbances with a large emotional component; and developmental anomalies.

In writing about behavorial disorders in children, the authors describe the many personality tests useful to and usable by the pediatrician. Es-

pecially helpful is the description of "drawing" tests.

The section on emotional development is brief and clear, authoritative but not exhaustive. Some of the headings include anger, fear, aggression, shyness, cruelty, sex, eating disturbances, nightmares, obesity, constipation and tics. This is followed by a discussion of antisocial behavior and by a review of such syndromes as autism, accident-proneness, compulsiveness, cerebral damage and schizophrenia. This large book makes one realize how much has been learned in this field during the past 50 years. The Bakwins have done an excellent job of culling, integrating and interpreting a vast literature and have produced a useful reference work that will earn its keep on the shelf of every pediatrician.

RALPH NEIL SHAPIRO, M.D.

Principles of Public Health Administration. By John J. Hanlon, M.D., M.P.H. St. Louis, 1960. Mosby. Pp. 714 with 40 figures and 51 Tables. Ed. 3. ($10.50)

In some respects, public health is one of the most thrilling specialties of medicine. Through its efforts, tuberculosis rates, infant mortality, venereal disease morbidity and the great plagues of the past have all been reduced or controlled. Public health, by its basic definition, cannot be the program of the private medical practitioner. It is team medicine *par excellence*. And where you have teams, you must have administration.

First published ten years ago, this widely read manual now appears in a new edition. Dr. Hanlon writes vividly and knows how to light up the drama of his subject. Perhaps social work and mental health are treated too superficially. But the rest of the material is solid, smoothly presented, and well documented. The author discusses statistical technics, personnel management, and health education. He reviews problems in fiscal management, public health nursing, environmental control and public health dentistry. Indeed, he touches on every phase of health—occupational diseases, nutrition, drug addiction, working with health agencies, accident proneness—even the behavorial sciences and social pathology.

Perhaps the private practitioner is too busy, or his work too sharply focussed to permit him to think much about public health. If so, here is a book which can add to his education. It is not only a fine handbook for the public health officer; it is, for the general practitioner, an introduction to the philosophy and principles of successful public health administration.

HENRY A. DAVIDSON, M.D.

Emergencies in Medical Practice. Edited by C. A. Birch, M.D. London, 1960. Livingston, Ltd.; Williams and Wilkins Co., Baltimore: U. S. Agents. Pp. 751. Ed. 6. ($8.50)

Now if only someone will publish an Americanized version of this handy text, we will all be happy. Drugs like Avomine or Centrimide are unknown to American pharmacy, as indeed are the "lamellae" which, the editor says, should be in every doctor's bag. The advice to treat headache with heroin sounds strange to American ears. (This drug has been outlawed in our country.) Apart from the problems produced by these trans-Atlantic differences, the book is excellent. It runs the entire gamut of medical emergencies—cardiovascular, neurologic, renal, obstetrical, and so on. There is a chapter on ship-board emergencies, one on medical emergencies in the air, and a third on emergencies in industrial medicine. A series of "practical procedures" at the end includes instructions on calling the London (England) police and on how to use the British Broadcasting Corporation facilities (phone Langham 4468 if London, England, is in your direct dialing area) to summon the relatives of sick patients. There is material on how to induce artficial pneumothorax, how to do a gastric lavage, and how to effect tidal irrigation of the bladder: all in all, a useful book that will soon earn its keep on the shelf or in the emergency bag.

ULYSSES M. FRANK, M.D.

Christopher's Textbook of Surgery. Edited by Loyal Davis, M.D. Philadelphia, 1960. Saunders. Pp. 1551, with 1600 illustrations. 7th. Ed. ($17.00)

Christopher's has become one of the old reliables of surgery. The present edition is compiled by the distinguished Chicago surgeon, Loyal Davis. The text includes contributions by 86 authors; indeed the roster of authors is a gallery of who's who in modern surgery. The bulk of the book is made up of chapters each covering a region—the eyes, the breast, the thyroid, the pancreas and so on; and in addition there are chapters on the training of surgeons, the history of surgery, and (uniquely) a final chapter called "surgical judgment." There is an excellent discussion of the management of postoperative convalescence, and thoroughly modern chapters on infections, wound healing and fluid balance. Each chapter is a veritable monograph. For example, the material on head injury describes and interprets the symptomatology in a manner that a neurologic text might well follow. The 50-page chapter on the female reproductive tract is a wonderfully compact textbook of gynecology. In almost every chapter, anatomy, physiology and diagnosis are given as painstaking a consideration as is surgical technic. The text, as a whole, is valuable manual and reference work that will soon earn shelf-space in any surgeon's library, regardless of his subspecialty.

VICTOR HUBERMAN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

FEBRUARY, 1961 • Vol. XXXIV, No. 2

SUSCEPTIBILITY AND IMMUNITY TO COMMON UPPER RESPIRATORY VIRAL INFECTIONS — THE COMMON COLD

Studies with volunteers show that many viruses are found in the nasal secretions of people suffering from the common cold and that physiologic and psychologic factors influence the symptoms. Infection causes immunity, but immunologic control may be difficult.

Common upper respiratory viral infections, despite their frequency, have been something of an enigma to physicians and scientists in general. Little has been known about their specific etiology and the factors that influence susceptibility or resistance to infection. A prevalent view, even within recent years, has been that there is a common cold virus to which only man is susceptible and which causes recurrent symptomatic infections without establishing immunity of the host. This concept now appears to be far too simple.

The present report gives results of experimental challenge of volunteer subjects with one of the common cold agents under controlled conditions.

Donors with naturally acquired typical common colds in the months from September to May have contributed specimens of nasal secretion. The secretions have been filtered free of bacteria and cells and stored at minus 90° F.

Students ranging in age from 18 to 48 have been challenged with a nasal secretion, usually diluted 100 times; a virus grown in tissue culture, or a salt solution. Symptoms were recorded for each day of the following week.

Nasal discharge was the symptom most uniformly recorded. It was the only symptom that was rated as severe. Sore throat, malaise, postnasal discharge, headache, cough, and sputum were frequent symptoms of moderate severity. Feverishness and chilliness were reported infrequently.

BACTERIA CULTURED

Bacteriologic cultures of the nasal specimens before and on the fourth, seventh, and ninth days after challenge were made for the detection of pathogenic microorganisms in the respiratory secretions. Some of the volunteers harbored staphylococci, hemolytic streptococci, or pneumococci in their prechallenge specimens. There was no apparent relationship between the presence of these microorganisms and the development of clinical symptoms.

Among a control group of volunteers who received uninfected buffer solution, there was a direct and statistically significant relationship between the usual number of colds per year reported by the subject and the likelihood of his developing symptoms of a cold in the experiment. Thus, among 23 subjects who reported five or more colds per year and who received the noninfectious control inoculum, 26 per cent developed a cold according to the criteria used in the experiments. Among the subjects who reported fewer natural colds and received uninfected material, there was a proportionately smaller number of experimental colds.

Attitudes exhibited before challenge showed that cold symptoms would be less likely to be reported by individuals who (1) did not believe they would develop a cold, (2) thought that emotional status did not influence physical

GEORGE GEE JACKSON, M.D.; HARRY F. DOWLING, M.D.; TRUMAN O. ANDERSON, M.D.; LOUISE RIFF, B.S.; JACK SAPORTA, M.S.; and MARVIN TURCK, M.D., *Annals of Internal Medicine, October, 1960.*

status, and (3) reported feeling no concern or worry over anything going on in their lives at the time of experimental challenge. A positive response to these three attitudes made it more likely that cold symptoms would be reported by the individual.

In regard to the effect of chilling on the common cold, the data show two important features: (1) among uninfected subjects, chilling did not activate latent viruses with the production of a clinical cold; (2) among subjects who received a uniform challenge, chilling did not increase the susceptibility to clinical infection.

Previous tonsillectomy had no influence on susceptibility or symptoms, nor did the smoking history of the person.

DISCUSSION

The causative agents of the common cold appear to be several, perhaps many, different viruses. These viruses produce both clinical and subclinical infections in man. Each of the viruses can produce a variety of clinical syndromes, commonly classified under categories of common cold, undifferentiated upper respiratory infection, and "flu." The common cold viruses cause afebrile, acute coryza in the great majority of persons. With a few exceptions, these viruses have not been isolated, named, or well characterized.

The common cold viruses are present in infectious form in both the cells and the fluid of nasal secretions; the titer is sufficient to suggest that droplet spray could be an effective means of communicating infection. Person-to-person transfer, presumably by droplet spray, was observed to cause clinical illness in approximately 10 per cent of persons exposed under experimental conditions and in 17 to 55 per cent among family members. The viruses in the community at different times, however, appear to be immunologically different, and some seem to cause sharp waves of epidemic illness, whereas others are more endemic.

The strong positive correlation between the usual number of colds per year by history and symptomatic reaction to an innocuous instillation appears to establish a wide range of difference in the proneness of persons to develop rhinorrhea or coryza. The data do not permit a conclusion as to whether physiologic or psychologic facts are dominant. On either basis, it is surprising that among the subjects who were hyperreactors to an uninfected solution, there was not greater susceptibility to clinical illness from a secretion containing an infectious agent.

For centuries men have associated the common cold with environmental chilling. The present data seem adequate to conclude that the basis of the association is not the direct activation of latent viruses by physical cold or physiologic reaction to chilling, since these factors did not produce colds without infection.

IMMUNITY

Previous epidemiologic and experimental observations that show insignificant immunity to the common cold have failed to recognize the number of specific viruses involved. Neutralizing antibody has been demonstrated in the serum and nasal secretion, and immunity to a specific rechallenge is as complete as that observed for influenza under natural conditions of infection. The duration of immunity is not known, but it appears to remain through at least one respiratory disease season.

These observations require the postulate that each viral upper respiratory illness is a specific infection, and thus that the number of viruses responsible for these infections is very great. Under the concept that the common cold is caused by many specific agents, each of which elicits an adequate immune response, the likelihood of discovering a predominant common cold virus that maintains this role for a long time is quite unlikely. If this is the case, the logistics for immunologic control of the common cold may be very difficult.

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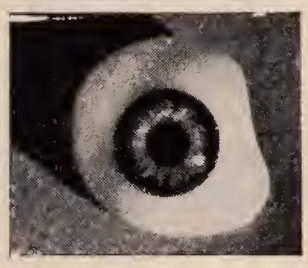
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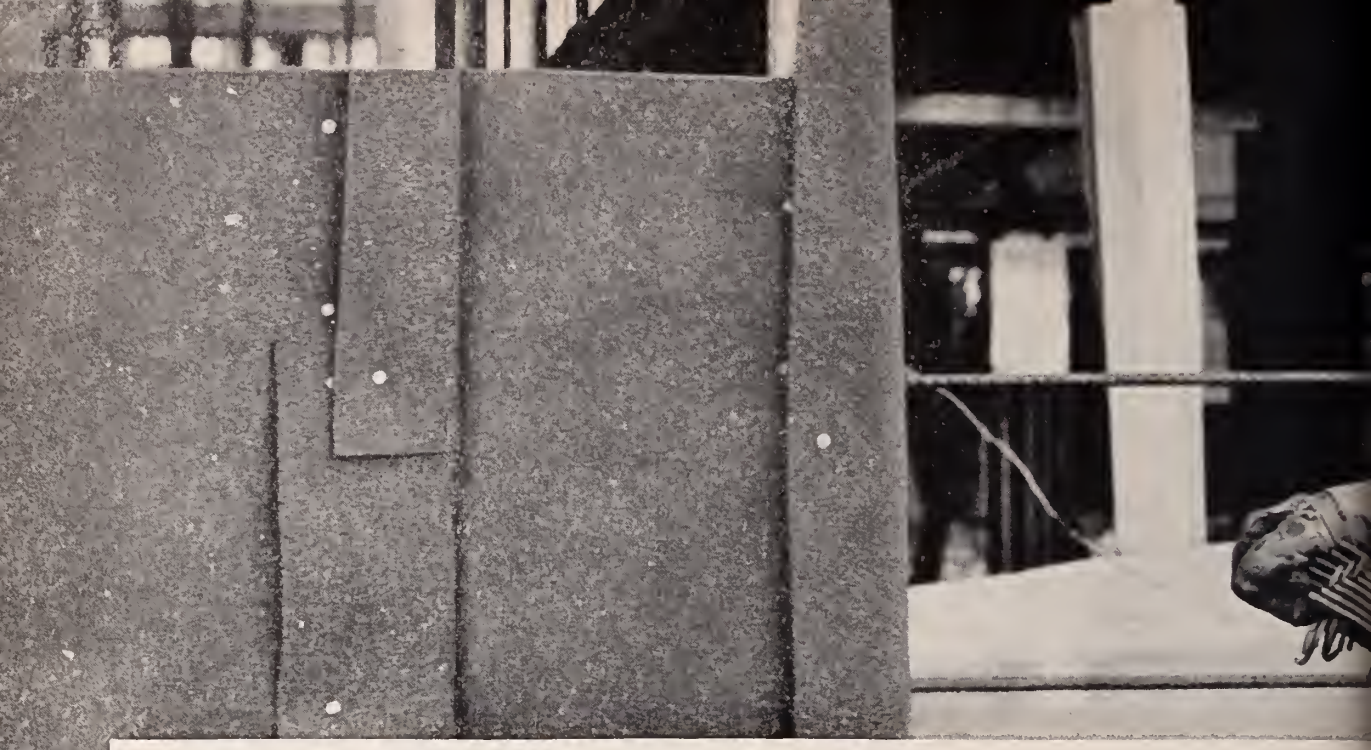
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Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 58, No. 3 MARCH, 1961 Subscriptions, $3.00 per Year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

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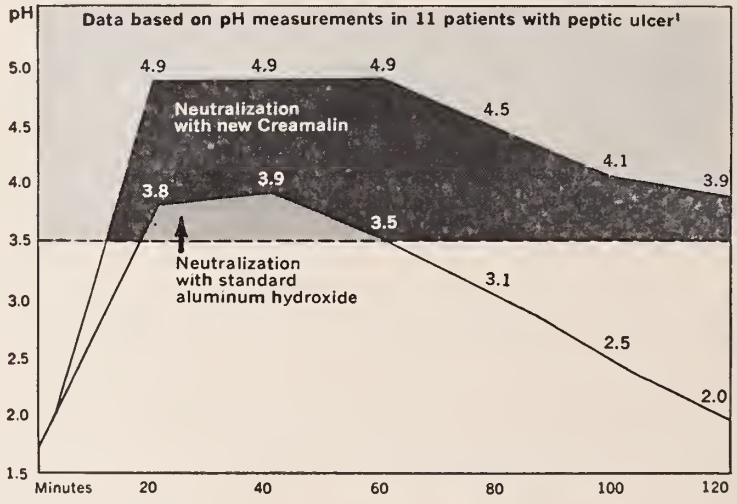
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

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References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Theropy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therop. Res. 2:92 (Mar.) 1960.

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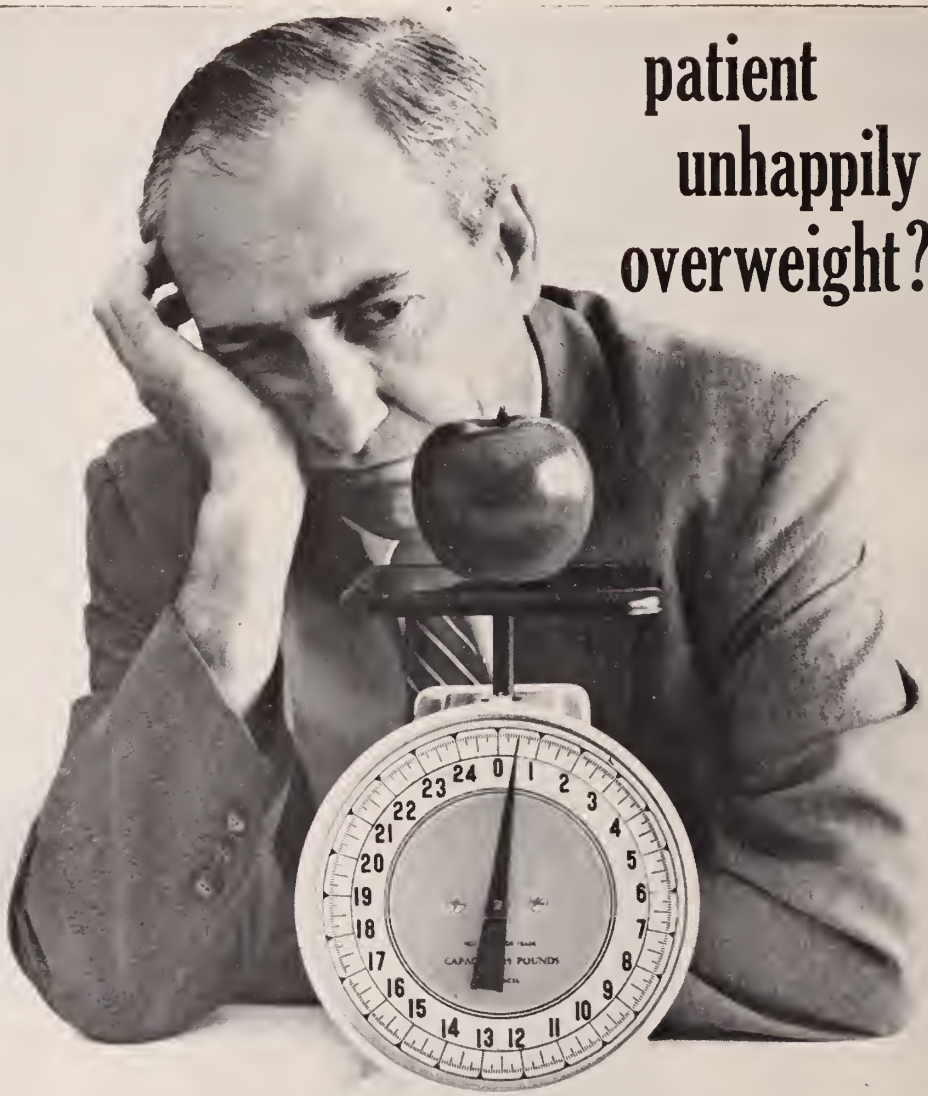
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[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

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*Pomeranze, J.: J. New York M. Coll. *1*:32, 1959.

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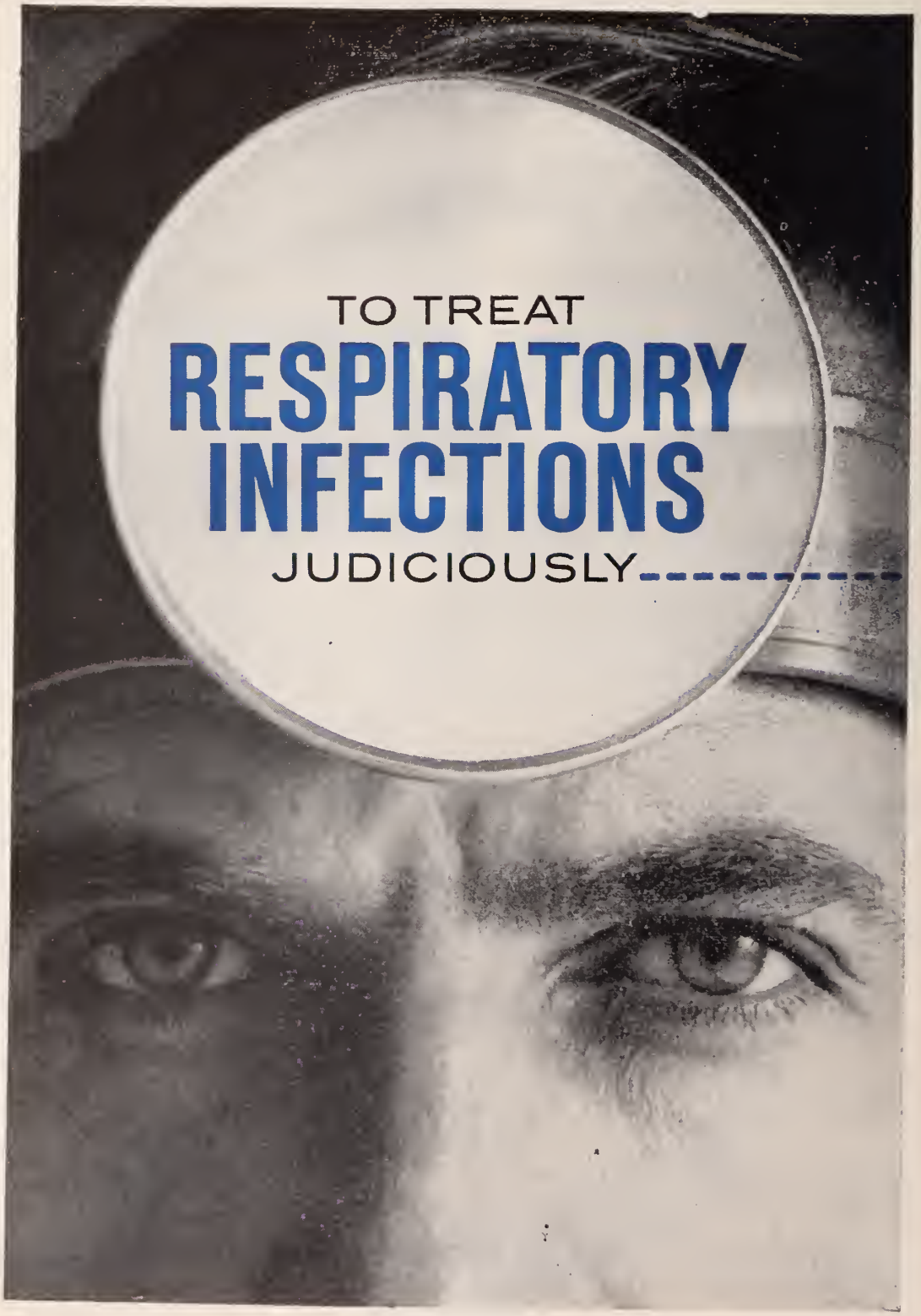
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Results	in 149, *good* results / in 40, *fair* results
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*MC GOVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K.D.: ANNALS OF ALLERGY 17:915, 1959.

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(1) Boehme, E. J.: Lahey Clin. Bull. 4:242, 1946. (2) Diamond, O. K.: New York J. Med. 59:1792, 1959.

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ADULT DOSAGE: As a hypotensive, one or two tablets 2 or 3 times daily. Usual maintenance dose one tablet twice daily. Doses in excess of 2 tablets daily should not be used in patients with a history of mental depression, peptic ulcer or ulcerative colitis.

PRECAUTIONS: Side effects occasionally observed include lassitude, drowsiness, anorexia, headache, dizziness and mild depression. Administer after meals to obviate gastrointestinal discomfort due to increased gastric secretion. Discontinue two weeks before shock therapy or elective surgery. In emergency surgery, use a vago-blocking agent to prevent anesthetic potentiation.

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Each tablet contains Reserpine 0.1 mg.
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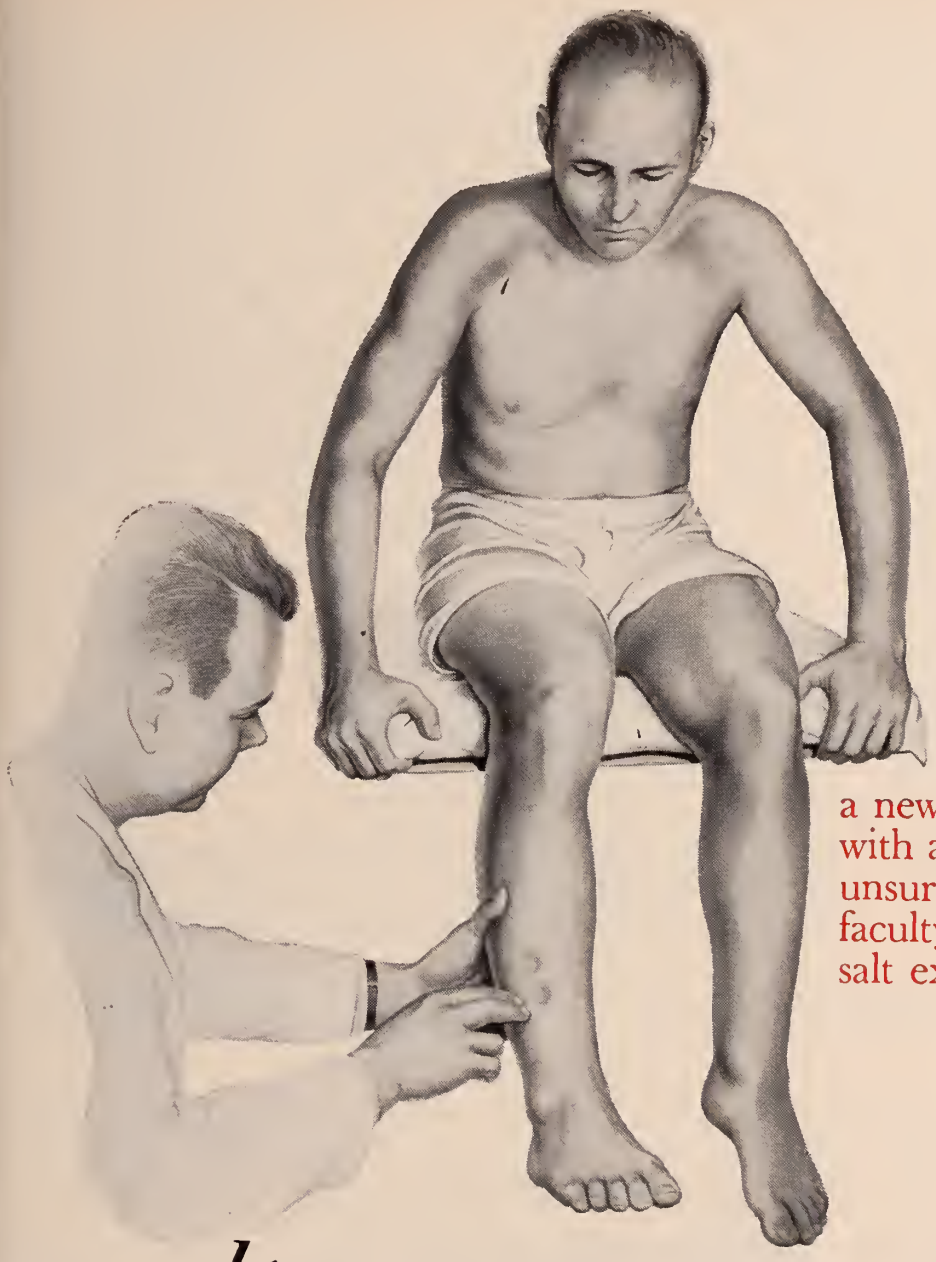
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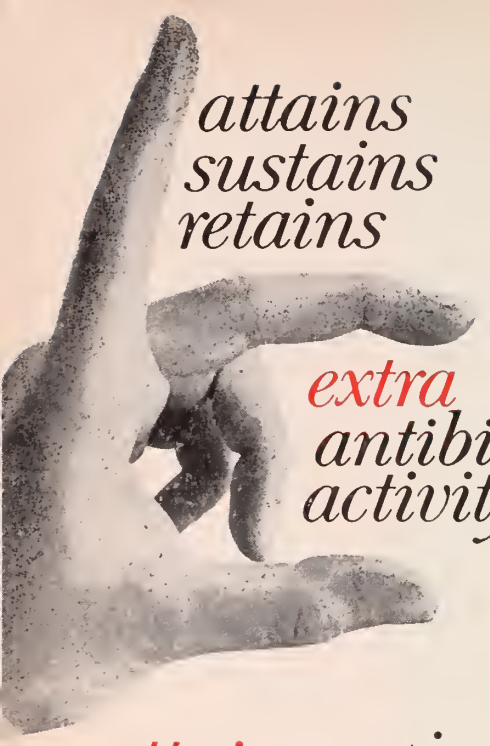
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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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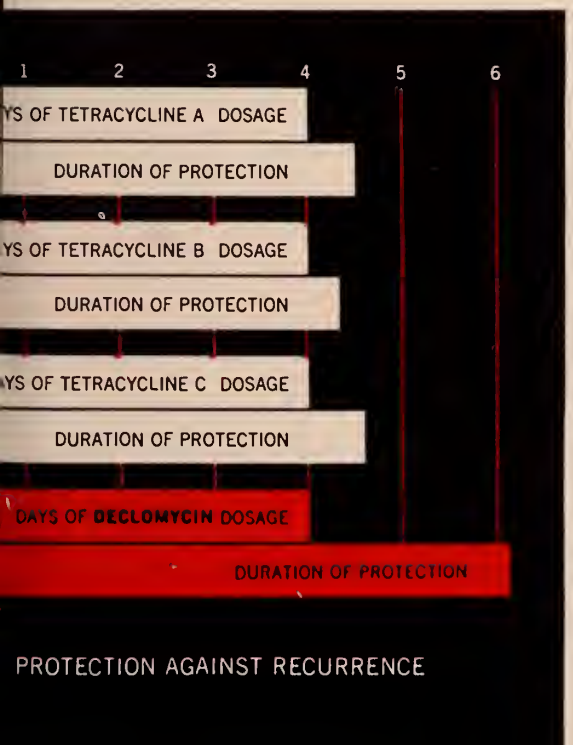


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*Council on Drugs, J.A.M.A. 165:58 (Sept. 7) 1957.

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov. 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2 Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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Editorials • • •

Medical Leadership in Rehabilitation*

Rehabilitation of the handicapped person to his maximum capacity for functional, social, and economic independence may require a coordinated process in which several professional groups participate. Some patients need only single services, such as physical or occupational therapy. Others require complete medical appraisal of the mental and physical status, including an analysis of the social background and the motivational factors and a vocational evaluation of employment potentials and capacity for retraining.

Rehabilitation begins with medical care rather than subsequent to it. The physician must rely upon social workers, therapists, and vocational counselors for their professional contributions. The physician is responsible for determining the level of mental and physical improvement the patient is likely to reach, the intensity of services the patient is capable of accepting, and the time such services should begin. It is his responsibility to be certain that health status is maintained at an optimal level.

These medical functions are shared by all physicians, regardless of specialty, who care for patients with any disease or disorder which may leave a residual disability. Responsibility cannot be left for the very small number of physicians who have chosen physical medicine and rehabilitation as a specialty.

Unfortunately, many physicians have not taken an interest in or accepted responsibility in regard to the rehabilitation aspects of their patient's medical problem. As a result, complaints of the following types are often made by nonmedical agencies administering reha-

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 679

VOL. 58, NO. 3 MARCH, 1961 Subscriptions, $3.00 per year
Single Copies, 30 Cents

bilitation programs, such as vocational rehabilitation, sheltered workshops, or welfare medical care.

1. Physicians frequently fail to provide the necessary medical information to assist the agency in determining the eligibility of the patient for the rehabilitation program.

2. Physicians often write down "totally disabled," without reporting clinical findings to back up such a statement.

3. Physicians too often state that no rehabilitation services are indicated, when it is known that patients with similar types of handicaps often show good responses to rehabilitation.

4. Several high quality facilities are having difficulties because they are not receiving sufficient referrals from the physicians in the community. Many patients are just not being referred for available services.

5. When patients are referred, the physician's request is often made for a single service, such as physical therapy or occupational therapy, when the person requires a comprehensive evaluation. Such persons often have problems in adjusting to their disabilities, which may be interpersonal or may relate to their dealings with their family or their community. On the other hand, it may be necessary for them to have a complete change in work habits or be trained for a new vocational field because the disability prevents them from returning to their former occupation. Thus, rather than a few physical therapy treatments a week, they should have a social evaluation and a prevocational counseling and testing service to be followed by actual vocational training if indicated.

6. Physicians rarely consider the current labor market or the jobs available when recommending handicapped patients for jobs. Physicians state that the patient is suitable for "light work," without having any idea of what "light work" involves. The classic example is the referral of a patient for a position as night watchman, when it is well known the watchman must make rounds through a multistoried building every hour and be ready to take quick action in case of fire or intruders.

Related to this lack of medical leadership is the tendency of many nonmedical agencies to take for granted that *they* are the leaders in the rehabilitation field and that physicians play a secondary role, as a source for which medical services may be purchased. This seems to reach a peak in the current federal legislative proposal for a program for "Independent Living Rehabilitation" (primarily a medical rehabilitation program for handicapped persons with no potentialities for return to employment) which would be placed in the vocational rehabilitation unit of the states. This bill (HR-3465) is being sponsored by the National Rehabilitation Association. The association declares that "only vocational rehabilitation counselors have the philosophy and the experience to undertake such a program." While holding that rehabilitation for independent living is *not* primarily medical, the statement emphasizes that the vocational counselors have had lots of experience in running medical programs, and are perfectly capable of doing so.

Thus we see the pattern characteristic of phenomena in other areas of medical care. Whenever physicians fail to exert leadership in medical problems, lay groups will step in and do it for them. Physicians should have and take responsibility for problems which are primarily medical.

Thus we must face the question of "who leads in rehabilitation." Medicine is not the only discipline concerned with the rehabilitation of disabled persons. However, the physician is a very important member of the team, and if he is not the captain, he would at least appear to be the quarterback. It is up to him to determine the medical potentialities of a patient and what the patient's mental and physical status will accept.

If the physician fails to carry out this role, there is the immediate danger of unfairness to the patient who may thus not achieve his full potentialities. There is also the long-range danger of handing over medical problems to nonmedical groups on a silver platter.

*Reprinted, with permission, from the April 15, 1960, New York State Journal of Medicine, this editorial is by I. J. Brightman, M.D., Assistant Commissioner of the N. Y. State Health Department.

Under the Weather

Who is under the weather? We are. Every man is under it and bathed in it. Man is the only animal who can survive in both the tropics and the poles. (Never mind bears. *Ursus maritimus*, the polar bear, is not the same species as *Ursus horribilis* which, believe it or not, is the zoologist's label for the grizzly). Every other animal—and every plant for that matter—has a climatic range and will not survive beyond it. But man lives in the arctic and lives in equatorial regions. The identical man, indeed, can jet-propel himself in a day from one zone to the other without suffering. *Homo sapiens* can laugh at weather. Or can he? Not quite.

There are, to begin with, diseases associated with the extremes of weather—like frost bite and heat stroke. Then there are the curious psychologic correlates of weather. The adjective "sultry" can describe a blond as well as a climate. Where barometric pressures are low, tempers are low. Beautiful spring days, and brisk winter days seem to make life worth living. Sunny Italy has contributed far more to human culture than Spitzbergen at 80° latitude or Biak at 0°. Charles Kingsley, in his *Ode to the Northeast Wind*, said that ". . . the hard grey weather breeds hard English men."

When our earliest ancestors were furry animals, we had insulation against the strong, bright sun with its bad as well as its good radiation. When we lost our fur, our skin became the surface that had to take all that the sun could pour down on naked man. The pearly-pink of the Caucasian became a liability, for it invited sunburn. Skin cancer is commoner among those with pale skin considerably exposed to the sun. Welton [1] has reported that in the Carolinas are a group of white-skinned farmers of northern European ancestry. Among these people, skin epitheliomata are extraordinarily common, some patients developing one every summer! Hopkins and Swank [2] have shown that multiple sclerosis exacerbates when the weather is unstable. Rheumatic fever patients do better in Florida or Arizona than in Maine or Minnesota. The patient in a hot climate needs more water and salt and the patient in a cold area needs more fat and carbohydrates.

Few physicians pay much attention to the weather. It seems, as Mark Twain is alleged to have said (he really didn't) that everybody talks about the weather but nobody does anything about it. The doctor usually contents himself with advice about buttoning up your overcoat. The major medical student of the weather was Mills [3] whose 21-year-old book on *Medical Climatology* is still the classic in the field. Mills accumulated impressive evidence of the effect of climate on health. He felt that the dissipation of internal heat was a major factor in the regulation of health, and this, in turn, depends on the temperature and humidity of the air around us. The problem is not only the question of absolute humidity or temperature, but also the changeability of weather.

The weather is, of course, as pervading as the air we breathe. Strange that we have so taken it for granted—so assumed our helplessness to modify it that we scarcely study its effects on human health. Wonder how it is that the old folks know that it ain't going to rain no more? The old folks are sensitive to the folk language, and the folk language talks of the weather. We could do worse ourselves.

1. Welton, D. G.: Wisconsin Medical Journal, 55:170 (February 1956).
2. Hopkins, C. and Swank, R.: Archives of Neurology and Psychiatry, 74:203 (February 1955).
3. Mills, C. A.: Medical Climatology. Springfield, Illinois, 1939. C. C. Thomas Company.

ALFRED D. SUMMERS, M.D.*
Princeton

The Care of Patients in a Long-Term Nursing Unit

Greater longevity is one of the effects of our increasingly more effective medical care programs. Too often, though, we purchase lower mortality at the price of greater morbidity. This imposes on us an obligation to do something about the aged sick. Here is one hospital's way of meeting that challenge.

MERWICK, a unit of Princeton Hospital, was opened in August 1957. The purpose of this facility is to provide long-term nursing care for patients who do not require intensive hospital care but who are not well enough to be cared for at home. Many of the patients are transferred to Merwick from the general hospital to convalesce from major surgical procedures. Others are admitted because of chronic disabilities requiring long-term care or rehabilitation.

Merwick is a three-story house which was remodeled and modernized and to which was added a modern three-story wing. It is on a nine acre tract on a residential street a half-mile from the main hospital buildings. It was originally designed to accommodate forty-two patients. Because of the heavy demand for private rooms with baths, some of the two-bed bedrooms have been converted to single rooms and thus, the present bed capacity is thirty-three. Admission to the Unit is controlled by a committee of three Attending Staff physicians. Any member of the Princeton Hospital staff may treat patients in the Merwick Unit. About 80 per cent of the patients are under the medical supervision of the writer. Administration is carried out by the Administrative Staff of the Hospital and board supervision is under a special committee of the Board of Trustees.

This paper reviews the discharges during the first three years of the operation of the Merwick Unit. It also deals with the various phases of the medical supervision of the Unit.

From August 1957 to August 1960, 104 patients were discharged. The oldest was 100 years and the youngest was 35. Average age was 80. There were 82 females and 22 males. Average stay was 6.2 months. There have been 20 deaths during the three years. The table gives a summary of the admission diagnoses and the causes of death.

DISEASES OF THE HEART AND BLOOD VESSELS

EIGHTEEN per cent had generalized arteriosclerosis to a marked degree; 15 per cent had hypertensive cardiovascular disease; 24 per cent had arteriosclerotic heart disease with cardiac decompensation; 12.6 per cent had cerebral arteriosclerosis with chronic brain syndrome; a very small percentage had rheumatic valvular heart disease, emboli of major

*Visiting Staff Physician to Merwick, The Elsie Procter Matthews Unit of Princeton Hospital.

DEATHS AT MERWICK 1957 - 60

Age	Sex	Admission Diagnoses	Cause of Death
93	F	Carcinoma of the colon	Metastatic carcinoma
95	M	Chronic nephrosclerosis	Chronic nephrosclerosis
90	F	Arteriosclerotic heart disease	Arteriosclerotic heart disease
68	F	Convalescent from surgery	Bronchopneumonia
88	F	Hypertensive arteriosclerotic heart disease	Acute myocardial insufficiency
82	M	Hypertensive cardiovascular disease	Cerebral hemorrhage
92	M	Arteriosclerotic heart disease	Cerebral hemorrhage
87	F	Generalized arteriosclerosis Coronoary insufficiency	Coronary sclerosis; Myocardial insufficiency
83	F	Carcinoma of the stomach	Carcinoma of the stomach
71	F	Parkinson's disease	Cerebral thrombosis
83	M	Myocardial infarct	Myocardial infarct: Acute pulmonary edema
88	F	Osteoarthritis	Carcinoma of the kidney
83	F	Fracture of femur	Massive hemorrhage of the adrenals
77	M	Arteriosclerotic heart disease	Arteriosclerotic heart disease
81	F	Carcinoma of the thyroid	Carcinoma of the thyroid
88	M	Old myocardial infarct	Coronary thrombosis
91	F	Generalized arteriosclerosis	Infarction of the spleen
86	F	Chronic myocarditis	Chronic fibrotic myocarditis
94	F	Arteriosclerotic heart disease	Arteriosclerotic heart disease
93	F	Carcinoma of the colon	Carcinoma of the colon

arteries, cerebral thromboses, and phlebothromboses of the large veins of the lower extremities.

In the treatment of the patients with cardiac decompensation, digitalization with digitoxin was carried out. As soon as digitalization was accomplished, the patients were placed on a maintenance dose of the drug and continued on it for the remainder of their stay in the Unit. Mercurial and thiazide diuretics were used when indicated to control edema of the lower extremities and "wet lungs." Repeated blood chemistries to check for electrolyte imbalance are imperative while diuretics are being used.

In atrial fibrillation, the ever-present danger of embolic accidents must be kept in mind. Two brief case reports follow:

A 69-year old retired nurse had hypertensive cardiovascular disease with atrial fibrillation. She was on a maintenance dose of digitalis. Unfortunately, she was allergic to quinidine so we were unable to use one of the more potent drugs to control her fibrillation. Early one morning she complained of a severe pain in her right leg and foot. The leg and foot were pale and cold, the peripheral pulses were not palpable. She was transferred to the hospital where a ¾ inch long clot was removed from the right femoral artery at about mid-thigh level. Circulation was re-established in the leg and foot and the patient was returned to Merwick. She was kept on anti-coagulant therapy for several weeks. For some reason unknown to us, her heart returned to normal sinus rhythm. She was discharged two months later and has been able to take care of herself in an apartment.

Case 2: A 77-year old housewife was admitted to the Unit following embolectomy from the right common iliac artery. She had suffered from cardiovascular disease for many years, and had had episodes of atrial fibrillation at intervals for the past two years. Without other symptoms, she suddenly developed a painful, pale, pulseless right lower extremity. An embolus was removed from the right common iliac artery in another hospital. She made a good recovery from the surgery and was transferred to Merwick to convalesce. After two months, she was able to return to her home. She has been normally active now for more than a year.

HYPERTENSIVE CARDIOVASCULAR GROUP

IN THE 15 per cent comprising this group, mild sedation, low sodium intake, and judicious use of the hypotensive drugs was the usual regimen. Too much or too fast a reduction of blood pressure in the elderly hypertensive frequently does more harm than good. Only in those with very high systolic levels were hypotensive drugs used; and then a gradual

reduction was attempted. There have been 12 cases of "cerebrovascular accident" treated over the three-year period. However, there have been only two cases of cerebral hemorrhage occurring after the patient was admitted to the Unit. There was also one cerebral thrombosis which occurred in a normotensive patient. Overtreatment of the elderly hypertensive is to be avoided.

CARE OF THE SKIN

THE care of the skin is often a serious problem in nursing homes. People in the seventh and older decades usually have thin, dry skin. In many, there is little subcutaneous fat to act as a cushion at the pressure points. Often the circulation is poor, particularly in the legs and feet. This increases the tendency to develop blebs, pressure sores, and localized infection.

The first bulwark against skin problems in the aged is good nursing care. The second is the best possible attainable nutrition. The third is to get the patient out of bed every day if at all possible. A short session in the wheel chair is very helpful. For the ambulatory, a walk up and down the corridors or outdoors will do a world of good. With a patient who must remain in bed, we have found the alternating pressure air mattress to be extremely valuable. When decubiti do occur, we continue using the air mattress and apply a silicon spray mist to the involved areas twice a day. We have also had some success with ointments containing corticosteroids.

PHYSICAL REHABILITATION

MERWICK has the full use and cooperation of the Department of Physical Medicine and Rehabilitation of the general hospital. The therapists make daily visits to the Unit to carry out prescribed treatment. During the three-year period, we treated 16 fractured femurs. All had the benefits of physical therapy here. All recovered sufficient function to walk, either with the aid of a "walker" or a cane. Many of them are now walking without mechanical aid.

In "cerebrovascular accidents" with hemiplegia, physical therapy is a valuble addition to the treatment regime. In the spastic type of paralysis, stretching of the muscles and ligaments, in addition to active motion as the nerve supply returns is gratifying to both the patient and his physician. In flaccid paralysis, early passive motion and massage are used before the muscles have lost their tone and atrophy has begun. In flaccid paralysis of the lower extremity, a well fitted brace may help in re-educating the patient to walk. Early treatment, within three or four days of the "cerebrovascular accident," is important in both types of paralysis.

THE RECREATIONAL PROGRAM

THE Merwick Unit employs a full-time Program Director. This is an important phase of the operation of the Unit for total care. She arranges picnics and "cook-outs" which encourage the patients to get out of doors and, incidentally, whet their appetites. Moving pictures on many subjects are shown in the recreation room. Also offered are lectures, musical entertainment and puppet shows. The Program Director also has charge of the arts and crafts. She is proud of one patient who is sort of a second Grandma Moses. Having never had a paint brush in her hand before coming to Merwick, she has done about 25 very creditable oils, some of which she sold at her first showing over a year ago.

SUMMARY AND CONCLUSIONS

A REVIEW of the 104 patients treated in a long-term nursing unit has been presented. The paper also discusses various phases of the operation of the Unit. A facility like this offers many advantages as part of a general

hospital. Among these are the close cooperation with all the departments of the hospital, including administration, nursing, dietary, housekeeping, and so forth. Physicians on the hospital staff are readily available for consultation, and the full facilities of the hospital are available for patients requiring surgery or more intensive medical care.

79 Bayard Lane

I am indebted to Miss Jewel Kennedy of the Medical Records Department for her help in preparing this paper. — A. D. S.

Educating High School Students About Smoking

Within the last 30 years, lung cancer has increased so rapidly that it is now killing 20 times as many people as it did a few years ago. Research points to smoking as a major cause of lung cancer. These warnings are muffled by the advertising of the cigarette industry. The upshot is public confusion and the obvious need for more educational campaigns by medical societies and other health organizations to alert the public to the real hazards of smoking.

Few medical societies have given this area of health education as much attention as the physicians of Broome County, New York. Cooperating with the American Cancer Society, the Broome County Medical Society recently organized a unique drive among high school students to point up the relationship between cigarette smoking and cancer. The experimental project, aimed at 14,000 students in the county's 24 public and parochial junior high schools, consisted of a series of 15-minute lectures, incorporating a Cancer Society filmstrip and pamphlet followed by a question-and-answer period.

Concerned over the vast amount of public apathy toward the potential dangers of smoking, BCMS physicians decided to tackle the problem before it really started, with an educational program at the junior high level. A high degree of success could be expected from such a program since the majority of this age group had not started smoking or had only recently started.

A special Smoking Education Committee, composed of 14 physicians, was appointed to organize lectures based on the latest data dealing with smoking at each of the county's junior high schools. In describing the purpose of the program, committee chairman, Dr. Mark H. Williams said: "Our feeling is that these boys and girls ought to be oriented on what is known. Then if they want to smoke—well, we cannot stop them."

Judging from the large number of questions asked the doctors following their presentations—ranging from "Does smoking slow down athletes?" to "Is smoking even a few cigarettes a day considered harmful?" the program generated a surprising amount of interest and enthusiasm among teenagers, in addition to clearing up a great deal of misinformation they had about smoking and its effects. The timely subject also netted a series of stories in the press, including a feature article titled "Forks Students Probe for Inside Smoking Dope," with accompanying photos of the lecture sessions.

As a follow-up, BCMS is drafting a questionnaire on smoking habits to be distributed to both junior and senior high students over the next four years. Data on smoking habits of both groups will be compared to determine whether the society's educational program had "any lasting effect on students' smoking habits."

—From the December 1960 *PR Doctor* (American Medical Association).

William J. Dougherty, M.D., M.P.H.

Trenton

New Jersey Poliomyelitis Immunization Experience*

July 1958 to June 1960

Poliomyelitis may be down but it's not out. There are still too many gaps in the fabric of our immunization program.

Following the completion of the poliomyelitis vaccine field trials and the commercial availabilty of Salk vaccine in 1955, New Jersey undertook to vaccinate its childhood population in a manner that appeared to be quite efficient. Complacency was shattered, however, by the 1958 outbreak, which demonstrated once again the unerring ability of an infectious agent to "zero in" on non-vaccinated persons. Less than 10 per cent of all patients with paralytic poliomyelitis in 1958 had received three inoculations of Salk vaccine.

The incidence of poliomyelitis in 1958 was high and only slightly reduced in the following year. In 1958 and 1959 there were 372 cases. Of these, 266 were paralytic. In each year the large number of patients who had not received Salk vaccine was striking. Comparative data for those years are presented in Table 1.

The obvious fact of incomplete immunization called for constructive action. The events and results recorded in this article demonstrate the ability of New Jersey's voluntary and official agencies to recognize a health problem, plan constructively, and achieve a practical result.

TABLE 1.

COMPARATIVE DATA FOR POLIOMYELITIS IN NEW JERSEY 1958 AND 1959

		1958	1959
Total cases		266	106
Deaths		10	7
Paralytic cases		186	80
Paralyzed cases confirmed by isolation	Type I	85	54
	Type III	34	9
Per cent of paralyzed under 10 years		56	56
Per cent of paralyzed triply vaccinated		9	30

1958 surveys

During the 1958 outbreak, the Newark Division of Health and the Jersey City Health Department, in cooperation with the State Department of Health, the Communicable Disease Center of the United States Public Health Service, and the nursing services of each city surveyed more than 10,000 persons. Nearly half of the children surveyed had *not* received Salk vaccine. Survey data are presented in Table 2.

TABLE 2.

PROPORTION OF CHILDREN NOT VACCINATED

POLIOMYELITIS VACCINATION SURVEY—1958

Age	Newark	Jersey City
0 to 4	50%	66%
5 to 14	30%	50%

*This article is in recognition of the efforts and accomplishments of members of medical, health, nursing, educational, and Parent-Teacher Associations throughout this state. Dr. Dougherty is Director, Division of Preventable Diseases, New Jersey State Department of Health.

PLANNING ACTION 1959

REPRESENTATIVES of statewide medical, health, nursing, educational, and parent-teacher organizations met in January and February of 1959 to consider means of achieving widespread poliomyelitis immunization among those who lacked the protection provided by poliomyelitis vaccine. The representatives endorsed five proposals:

1. The Medical Society of New Jersey resolution encouraging poliomyelitis immunization as a prerequisite for admission to school.

2. Cooperative surveys to determine the status of poliomyelitis immunization, particularly in low socio-economic groups.

3. Aggressive poliomyelitis immunization programs, planned cooperatively by health departments, medical societies, and community agencies.

4. Expansion of existing local health department immunization programs in areas of medical indigency.

5. Surveys in Atlantic City, Bayonne, Camden, Elizabeth, Hoboken, Jersey City, Newark, Paterson, and Trenton.

In the course of these meetings, representatives of the State Department of Health and The Medical Society of New Jersey considered the survey procedures and agreed that:

(a) Local health departments, in cooperation with appropriate county medical societies, would determine areas of incomplete immunization associated with low socio-economic status and medical indigency.

(b) Local health departments would establish and medical societies assist in staffing facilities for administering poliomyelitis immunization to non-immunized persons up to 20 years of age.

(c) The services of the immunization facilities would be limited to residents of those areas defined as "medically indigent" by health departments and medical societies.

(d) Persons living in the defined areas would be urged to use immunization services through organized community efforts.

1959 SURVEYS

SAMPLING surveys were undertaken in Atlantic City, Bayonne, Camden, Hoboken, and Trenton. In each city, persons familiar with its characteristics assisted in the definition of high, middle, and low socio-economic areas.

Information was obtained on 7,279 persons through 39 years of age. The sample was heavily weighted by persons in the middle and low socio-economic groups. For example, only 524 persons were sampled in the upper socio-economic group.

Half of the people in the middle and low socio-economic groups, had *not* received Salk vaccine. Only 28 per cent of children under 5 years and 50 per cent of children 5 to 14 years had received three or more inoculations. The highest level of triple inoculation[2] (71 per cent) was found in the 5 to 14 age group in Trenton. See Table 3.

The Newark Division of Health undertook a door-to-door survey. By mid-summer 1959, this revealed 7,692 persons through 18 years of age who had received three injections of poliomyelitis vaccine and more than 2,000 persons who had received no Salk vaccine.

In Jersey City, a survey of 2,860 persons (principally in low socio-economic areas) indicated that only 32 per cent had completed a series of Salk inoculations. A study in Elizabeth[3] showed that in high income sections, with a total school enrollment of more than 4,300

TABLE 3.

PER CENT OF PERSONS HAVING THREE INOCULATIONS
POLIOMYELITIS IMMUNIZATION SURVEY
SELECTED CITIES IN NEW JERSEY—1959

Per Cent Triply Inoculated

All Cities	Atlantic City	Bayonne	Camden	Hoboken	Jersey City	Trenton
34.2	62.7	30.2	28.6	37.0	32.0	43.0
28.4	48.1	31.0	28.3	20.6	21.4	39.6
51.1	85.7	60.0	49.0	66.5	40.0	71.7
19.9	49.0	16.7	13.9	27.0	18.9	25.7

students, 76 per cent had received at least one injection. In low income sections, with an enrollment of about 6,000 students, only 59 per cent had received at least one inoculation.

The Poliomyelitis Vaccine Committee of the Passaic County Medical Society and the Passaic County Chapter of the National Foundation, assisted by the Civil Defense organization, conducted a survey which stirred thousands of persons to action. More than 20,000 poliomyelitis vaccine inoculations were given. Eighty per cent were first or second doses.

EFFECT OF 1959 SURVEYS

THE newspaper publicity, the activity of professional organizations, visitations to homes, the neighborhood impact of the survey, and the survey findings served to stimulate widespread immunizations. Cities surrounding major sampling areas undertook surveys of their own.[4,5] This multiplying effect contributed to wider immunization than could have been expected from the individual surveys. This activity continued throughout the year with the result that during the calendar year 1959, a total of 1,785,000 doses of poliomyelitis vaccine were shipped into the state: 1,113,000 to commercial outlets and 672,000 doses to public agencies.

SCHOOL SURVEY PLAN DEVELOPED

IN SEPTEMBER, 1959, it was evident that many children still had not received poliomyelitis vaccine. Representatives of the statewide organizations who had successfully assisted in the spring program again met and agreed to a plan for surveys in school districts and schools that did not have requirements for poliomyelitis immunization. It was recommended within the plan that intensive poliomyelitis vaccination programs be carried out in areas where studies revealed incomplete immunization.

Questionnaires were forwarded to 525 public school districts and to 497 parochial schools. Four hundred and forty-six public school districts replied to the questionnaire, 185 districts indicating that there were no poliomyelitis immunization requirements in effect. Three hundred and seventy-one parochial schools replied; of these 142 had no poliomyelitis immunization requirements.

In many schools, the requirements for immunization existed only for admission to kindergarten and the first grade.

SCHOOL SURVEY ACCOMPLISHED

SURVEYS to determine the extent to which pupils were vaccinated began in the late fall and early winter and continued throughout the spring until June of 1960. These surveys (Table 4) indicate that over 80 per cent of the children in the schools having no immunization requirements have received three or more inoculations of poliomyelitis vaccine.

SURVEY OF YOUNG CHILDREN

THE sampling surveys in New Jersey in the spring of 1959 indicated that only 28 per cent of the children sampled under 5 years of age had received three inoculations of poliomyelitis vaccine (Table 3). This prompted a recommendation that each board of health study a sample of children between 1 and 2 years of age to determine their immunization status.

One hundred boards of health throughout New Jersey conducted the poliomyelitis immunization survey among children 1 to 2 years of age. A total of 6,472 questionnaires were forwarded to parents. Four thousand seven hundred and thirty questionnaires were returned. Table 5 indicates that 71 per cent of the children in this survey had received 3 or more inoculations of poliomyelitis vaccine. The highest levels of protection were observed in the Northern and Metropolitan Districts where 80 per cent of children studied were triply inoculated.

As the 1959 surveys stimulated immunization programs, in like manner extensive im-

TABLE 4.

PER CENT OF CHILDREN HAVING POLIOMYELITIS IMMUNIZATION

POLIOMYELITIS IMMUNIZATION SURVEY
PUBLIC AND PAROCHIAL SCHOOLS
NEW JERSEY, 1960

State Health Districts	Type of School	Number of Schools	Number of Children	Per Cent Number of Inoculations None	3 or More
All	Public	165	158,147	8.4	81.1
	Parochial	78	47,378	10.4	79.4
Metropolitan	Public	72	91,543	7.4	83.5
	Parochial	61	37,799	11.6	78.8
Central	Public	61	50,723	10.6	77.1
	Parochial	2	1,378	5.0	75.8
Southern	Public	22	10,839	6.9	79.6
	Parochial	15	8,201	5.7	82.5
Northern	Public	10	5,042	7.8	79.2

TABLE 5.

CHILDREN HAVING POLIOMYELITIS IMMUNIZATION

BOARDS OF HEALTH—NEW JERSEY
JUNE, 1960

Area of State	Number of Boards of Health	Number of Children	Per Cent Number of Inoculations None	3 or More
Total	100	4,730	2.9	71.4
Metropolitan	62	2,783	4.3	77.9
Northern	17	444	5.8	77.9
Central	12	525	11.8	63.8
Southern	9	978	17.0	54.7

munization activity occurred in the spring of 1960. This is revealed by the fact that in the first six months of 1960, 848,564 doses of vaccine were received in the State.

DISCUSSION

THE question has been asked, is poliomyelitis vaccine effective? Concern has been expressed because an increasing proportion of paralytic cases have been found to have been vaccinated. For example, in 1958, less than 10 per cent of the paralytic cases reported were triply inoculated; in 1959, 30 per cent of the paralytic cases had received 3 or more doses of vaccine.

As we continue immunization programs and more and more persons are vaccinated, it is, then, inescapable that among the vaccinated there will be some cases of poliomyelitis. *The occurrence of cases among vaccinated individuals does not challenge the effectiveness of the vaccine.* A few people, for reasons not yet known, do not react to poliomyelitis vaccine just as others do not react to smallpox vaccine and to other types of immunizing agents.

Langmuir [6] has described effectiveness ratios for poliomyelitis vaccine. These are developed from data obtained in September, 1959 by the National Health Survey. While the estimates pertain to the population of the nation as a whole (and there may be some local bias) nevertheless an effective ratio of 80 to 90 per cent for 3 inoculations and 90 plus per cent for 4 inoculations or more is a valid conclusion in spite of bias.

In the studies thus far, we have been impressed by the continued tendency of unvaccinated children to appear in low socio-economic areas. With the present vaccine effectiveness clearly established, our next task is to bring poliomyelitis immunization to the small, poorly immunized segments of our communities.

SUMMARY

1. Paralytic poliomyelitis in 1958 affected young non-vaccinated persons. Less than 10 per cent of paralytic cases had received three inoculations of Salk vaccine.

2. In 1959, paralytic poliomyelitis continued to occur in the non-vaccinated group under 10 years of age.

3. Immunization surveys in 1958 revealed that between 30 and 50 per cent of children through 14 years of age had not received Salk vaccine.

4. Surveys in major cities in 1959 showed that 28 per cent of children under five; and 50 per cent of children five to 14 had received three or more inoculations.

5. Surveys in the winter of 1960 in schools having no immunization requirements revealed that 80 per cent of children had received three or more inoculations of poliomyelitis vaccine.

6. Surveys conducted by 100 boards of health in 1960 indicate that 71 per cent of children under two years had received three or more inoculations of poliomyelitis vaccine.

7. Over 2.5 million doses of poliomyelitis vaccine were shipped to and used in our State between January 1, 1959 and June 30, 1960.

8. The United States Public Health Service estimates an effectiveness of 80 to 90 per cent for three inoculations; and 90 per cent plus for four inoculations of poliomyelitis vaccine.

9. A vigorous immunization program to reduce the number of non-protected children in hard to reach, low socio-economic groups is a continuing need.

The State Department of Health

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Surgery for Parkinsonism

Twenty-six victims of paralysis agitans were treated by these four surgical technics: (1) Pallidectomy with destruction of the globus pallidum by alcohol on 5 patients. Immediate results were satisfactory, with cessation of tremor and decrease of rigidity. One patient went into irreversible coma. Postoperative contralateral facial hemiparesia persisted in one. (2) Electrocoagulation on three patients. The postoperative period was complicated by fever and cerebral edema in two patients, one of whom died. The two surviving patients obtained permanent improvement. (3) Destruction of globus pallidum with leukotome on five patients, of whom one died during the operation. Immediate results were satisfactory in the others. (4) Destruction of globus pallidum by combined cutting and injection of boiling water on 19 patients. With the exception of one patient, permanent improvement was obtained. Pallidectomy with injection of boiling water is considered safer than, and as effective as, the other technics.

—M. B. Vallis in the Spanish Journal, *Rev. esp. otoneuro-oftalm*—(Feb. 1960) 19:30

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Clinical Evaluation of Hydrochlorothiazide*

Hydrochlorothiazide was found to be more effective as a diuretic in salt retention type of edema than in ascites due to liver disease.

The mechanism of kidney physiology is not well understood. In 1943, a basic research project [1] was started to unravel some of the mystery of renal function. Stimulation for effort came from the swift excretion of penicillin through the kidney. So rapid was the elimination that the concentration was lost before the drug could do its antibiotic work.

One of the major pharmaceutical companies launched a renal program, headed by Drs. Sprague and Beyer, in search for a compound to control the rapid excretion of penicillin. This effort gave to the profession a fuller knowledge of renal function [2] and probenecid.[3]

In 1949 Schwartz [4] observed that sulfanilamide in large doses had diuretic properties. This was especially true in subjects with edema. He also demonstrated[4] that chemical substances could select excess sodium for excretion through the kidney. The work in renal physiology, the report of the diuretic properties of sulfanilamide and the clinician's demand for a satisfactory oral diuretic agent set off a mass screening program in the drug industry, in search for such a compound.[1]

In 1950, Roblin and associates [5] reported an effective oral diuretic, acetazolamide (2 acetylamino 1-3-4 thiodiazole, 5 sulfonamide.) This was a much improved diuretic. Its mechanism led to certain undesirable side effects. It causes a bicarbonate and potassium diuresis, resulting in hyperchloremic acidosis and in the potassium depletion syndrome. The action here and that of sulfanilamide is carbonic anhydrase inhibition.[6] With these disadvantages the indications for acetazolamide are limited.[7] Therefore, the search continued for the compound postulated by Beyer.[3] By 1951, Beyer and Sprague[8] had ready for clinical use a compound effective in inhibiting the rapid excretion of penicillin, probenecid. However, by this time penicillin was available in quantities that eliminated the pressing need for such a drug.

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*Presented May 17, 1960 at the Annual Meeting of The Medical Society of New Jersey.

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In 1955, Novello[9] synthesized chlorothiazide, an aromatic sulfonamide which causes the excretion of sodium and chloride in almost equal amounts. In 1957, Novello and Sprague[9] reported chlorothiazide as a potent diuretic of sodium and chloride. Further clinical investigation[10] showed that with the maximum effective dose (2000 milligrams daily) in noncardiac edema states, there is a spontaneous tendency to hypokaliemia.[11] Because of the clinical significance of this undesirable feature the search continued to find a sulfonamide derivative that would cause a sodium, chloride, and water diuresis and spare potassium.

In 1958, deStevens and his associates[12] reported the synthesis of a new sulfonamide with diuretic action, hydrochlorothiazide. This compound differs from chlorothiazide by hydration of the heterocyclic ring. It is effective in much smaller doses, causes more of a chloride, sodium, and water, and less of a potassium diuresis. Its maximum effect is obtained with 200 milligrams or less daily.[10] The pharmacologic action of these compounds differs from that of acetazolamide in that chlorothiazide and hydrochlorothiazide do not seem to act as an inhibitor of the carbonic anhydrase enzyme system,[14] or at most to a much lesser degree.[15] In some manner, obscure at this time, these agents inhibit the reabsorption of sodium,[13] chloride,[14] potassium[15] and water at the renal tubular level.[16]

A clinical study is offered of 30 patients with edema and hypertension, who were treated with hydrochlorothiazide.

Purpose of the study was to determine the effectiveness of this drug as a diuretic in edema states; and also, its value as an antihypertensive agent. The cases include some of edema due to congestive heart failure, renal insufficiency, and cirrhosis. Those with hypertension were observed for the effect on systolic and diastolic blood pressure.

METHODS AND MATERIAL

HYDROCHLOROTHIAZIDE was available in its oral form as 25 milligram and 50 milligram scored tablets. In the early cases, the dosage was calculated 3 milligrams per Kilogram of body weight daily, given as a single dose or in divided doses. Later 200 milligrams was the maximum daily dose. Of the 30 patients treated, 25 had edema; 15 were in congestive heart failure; 4 had the nephrotic syndrome; 5 had cirrhosis with ascites; and one had edema of undetermined origin. There were 5 hypertensive patients with systolic blood pressure of 170 or more. The selection of cases was at random from clinical material presented on the Medical ward service of a general hospital.

Careful history and physical examination were done to determine the category of study. Basic laboratory studies on all cases were: hemoglobin, hematocrit, white count, differential, urea nitrogen, serum electrolytes, urinalysis, chest x-ray and electrocardiogram. Additional laboratory studies were done on patients with liver and renal disease, to confirm the diagnosis and estimate the degree of impairment.

Intake and output were recorded on all patients. Serum electrolytes were repeated every 5 days. All patients were on low sodium diets. All laboratory determinations were done in the fasting state. Patients receiving a single dose regimen were given the drug at 6:00 a.m., divided doses usually at 6:00 a.m. and 2:00 p.m. The electrocardiogram was repeated on the fifth day. Fasting body weight and resting blood pressure were determined daily.

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RESULTS

The study of the 30 patients treated with hydrochlorothiazide revealed the following: The 15 cases of congestive heart failure included 6 females. For the fifteen the age range was from 17 to 83 years. Ten showed a significant weight loss and symptomatic improvement. The remaining 5 patients had less than five pounds of weight loss, but improved clinically. After an initial fall of the serum electrolytes, sodium, potassium and chloride, during the first week of therapy, a gradual return toward normal was noted. Three patients received supplemental potassium chloride as a prophylactic measure. No change was noted in the electrocardiogram during alteration of serum electrolytes and blood pressure was not significantly influenced by the medication in this type of case.

Four cases of the nephrotic syndrome were studied. Three had the Kimmelstiel-Wilson syndrome. The fourth had nephrosis with proliferative glomerulonephritis. There were three males and one female in the age range from 28 to 69 years. All showed a marked weight loss due to diuresis as calculated by intake and output. Two with Kimmelsteil-Wilson syndrome died in renal failure. The other two were discharged as clinically improved. All had moderate hypertension, elevated urea nitrogen and a PSP of less than 20 per cent in 30 minutes. Three showed a definite depression of serum electrolytes, sodium and chloride, two a depression of potassium and carbon dioxide. One lost 37 pounds without appreciable alteration in the electrolytes, sodium, chloride, potassium and carbon dioxide. Average weight loss in this group of 4 patients was 33½ pounds.

Five cases with cirrhosis and ascites were studied. In this group there were three females and two males ranging in age from 36 to 62 years. Diagnosis was established by laboratory studies and, in some instances, by liver biopsy. Three of the patients had paracentesis before the drug was started either for diagnostic purposes or to relieve acute distress. All received from 100 to 200 milligrams of the drug daily, in single and divided doses. Three showed a weight loss of 5 pounds or more. Of the other two, one without paracentesis went from 115 to 142 pounds during her 22-day hospital stay. The other patient had a weight loss of 4 pounds after 12 days of medication. All were on high carbohydrate, low salt diets. The sodium, as in the other groups, was initially depressed, but began to rise toward normal by the fifth day. Potassium was reduced in all but one case; here it rose from 3.7 mEq to 5 mEq but by the end of his 30-day hospital stay, the level had returned to 3.7 mEq. Three required supplemental potassium because of a rapid fall of the serum level to 3.5 mEq or less. One (showing no change in serum potassium) had cardiac cirrhosis associated with rheumatic heart disease. The other had severe anemia and moderate renal insufficiency. The chlorides and carbon dioxide stabilized and did not show a characteristic curve. Two patients did not have paracentesis; one of these lost 8 pounds, the other gained 27 pounds. All patients were on supportive regimen, including correction of concurrent pathologic conditions.

The one patient with edema of undetermined origin had bronchogenic carcinoma with hypertrophic pulmonary osteo-arthropathy. The serum electrolyte pattern was one of sodium, chloride, and potassium depression. Sodium chloride was administered when serum sodium fell to 123 mEq after 13 days of therapy. The drug was discontinued two days later. Hydrochlorothiazide was the only diuretic used and produced a weight loss of 18 pounds with a disappearance of the peripheral edema.

Five patients with hypertension, four females and one male, ranging in age from 43 to 60 years, were followed. On admission, systolic blood pressures were between 170 and 290. Diastolic pressures ranged between 70 and 160. One patient with moderate hypertension received hydrochlorothiazide alone. The remaining four were given reserpine and/or pentolinium tartrate as an adjunct. Patients in this group showed satisfactory fall in blood pressure. Three returned to normal

levels; one remained at 160/60; one died of uremia as a result of malignant hypertension.

A state of hyperuricemia was reached in five of the thirty cases in this series. Two had congestive heart failure; one cirrhosis with ascites; one with renal insufficiency; and one with hypertension.

Twenty-four hour urinary electrolytes were measured in two cases of congestive heart failure during the first day of hydrochlorothiazide therapy, and five days later. Results were:

	Na Excretion	Cl Excretion	K Excretion
Case No. 11 CHF			
Day 1	90.4 mEq	110.5 mEq	44.2 mEq
Day 5	76.7 mEq	58.5 mEq	41.5 mEq
Case No. 13 CHF			
Day 1	105.3 mEq	96.5 mEq	16.5 mEq
Day 5	45.0 mEq	52.0 mEq	43.0 mEq

Results of this study indicate (even though there were a limited number of patients in each group) that hydrochlorothiazide is a potent diuretic agent in the so-called "responsive edemas" of different origin, as well as a valuable adjunct in the treatment of hypertension. Our findings are reviewed below in correlation with the literature.

Hydrochlorothiazide is effective by oral administration [18] at a dosage level of 200 milligrams daily or less. Its action is one of electrolyte and water diuresis, with sodium and chloride being markedly influenced. A lowering of the serum electrolytes is most noticeable during the first five or seven days of therapy, with spontaneous return toward normal thereafter in most instances. This seems to be due to a renal mechanism [19] of electrolyte conservation [20] acting as a protective factor against profound electrolyte imbalance.[21] This is also reflected in a decrease of urinary excretion of electrolytes on the fifth day of therapy.[20] Little change was noted in the carbon dioxide levels in cases of congestive heart failure, cirrhosis and hypertension. It remained low in those with renal disease.

A tendency toward hepatic coma was not observed in the cases of liver disease treated with hydrochlorothiazide. Alterations in the serum electrolytes were noted, especially in potassium, but the diuretic effect was poor in the subjects of this group.

THE hypertensive group showed but little weight loss. The serum electrolytes followed the pattern of those in the edema states, except for potassium which seemed to be less affected. In all but one case, hydrochlorothiazide was used in combination with other antihypertensive drugs (reserpine and pentolinium tartrate). Chart [14] states that reserpine in animal experiments is known to have an antidiuretic effect. This is partly abolished by hydrochlorothiazide.[15] Others attribute the antihypertensive property of hydrochlorothiazide to sodium diuresis.[20]

Replacement therapy was instituted when laboratory findings suggested electrolyte depletion. Even though serum sodium and potassium were below normal at times, we were unable to demonstrate evidence of the electrolyte imbalance syndrome by clinical picture or electrocardiogram. The U-waves reported by others were not observed.[18]

The base line values for 24-hour urinary electrolytes in patients on low sodium diets was taken from the work of Ford and his associates:[21] Na 50 mEq.; K 40 mEq.; Cl 25 mEq. In the two cases in which the 24-hour electrolyte excretion was measured, an increase of these solutes was found, indicating that if there be a salt retention type of edema, hydrochlorothiazide will promote an electrolyte diuresis. No toxic effects were noted in the dosage used.

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SUMMARY

TWENTY-FIVE patients with edema and ascites and five patients with hypertension were treated with hydrochlorothiazide to evaluate the drug as a diuretic in edema states and as an antihypertensive agent.

1. Hydrochlorothiazide was found to be an effective diuretic in the so-called "responsive edema" states (the salt retention type of edema). Its action is that of electrolyte-water diuresis. This action causes a depression of the serum levels of sodium, potassium, and chloride but they tend to return to normal.

2. In ascites due to liver disease the diuretic action was unimpressive. The effect on serum electrolytes was similar to that in edema states of other causes, except potassium which was depressed to a greater degree.

3. Four of the five patients with hypertension were treated with hydrochlorothiazide in combination with other hypotensive agents; one with moderate hypertension with hydrochlorothiazide alone. All showed satisfactory response to therapy, indicating that the drug is a potent adjunct in a regimen for the treatment of hypertensive disease. However, the group is small and no general conclusion can be safely drawn from this brief experience.

4. The dosage range need not exceed 200 milligrams daily for maximum effect. No toxic manifestations were observed. Hyperuricemia was noted in 5 of the 30 cases treated but there was no clinical evidence of gout.

5. The level of serum electrolytes did not present a clinical picture of electrolyte imbalance. Supplemental therapy was given on the basis of laboratory determinations.

1882 South Tenth Street

Lung Cancer Rises as Lung TB Falls

A decline in deaths due to tuberculosis was suggested as a factor in the increasing occurrence of lung cancer, in the December 31, 1960 Journal of the American Medical Association. Drs. Broda O. Barnes, Denver, and Max Ratzenhofer, Graz, Austria, said more persons were surviving TB early in life only to contract lung cancer in their later years. They predicted that "a large increase" in lung cancer could be expected as tuberculosis deaths continue to decline.

Their conclusions were based on data from 26,546 autopsies performed during 15 years at the University of Graz.

The study showed that "a great reduction in tuberculosis is occurring in Graz, as elsewhere." It also showed that the average age of patients who died from tuberculosis was rising.

"In 1944, the average age at death was 38 years, while in 1957 it was 54 years. The tubercular patient was approaching the 'cancer age' before death." Tuberculosis and lung cancer are not found frequently in the same person at the same time. "There are two diseases competing for the same person: tuberculosis at an early age and bronchogenic carcinoma as he grows older." They calculated that "countries with a high incidence of tuberculosis would have a low incidence of bronchogenic carcinoma and *vice versa,* unless other factors are present." They added that "a large increase in bronchogenic cancer can be expected as the death rate from tuberculosis decreases.

"At the turn of the century, the United States had about 200 deaths per 100,000 from tuberculosis. If the same proportion of the population is susceptible to tuberculosis today, and if 20 per cent of this same population is susceptible to bronchogenic carcinoma, then 40 per 100,000 might succumb to lung cancer when tuberculosis is eradicated. This conjecture illustrates that a further increase in bronchogenic carcinoma may be expected."

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Montclair

Types of Athletic Injuries in Various Sports*

Prevention and Primary Treatment

The medical profession (with some honorable exceptions) has not taken too seriously its duty to provide medical monitoring for athletic events.

In recent years, I have been orthopedic consultant and team physician for Montclair State College, and so have met the problem of athletic injuries. In addition, as a practicing orthopedist, I see many of the more serious orthopedic injuries of high school students in our area.

I have compiled some statistics of my experience at the State College. We evaluated 130 of the more serious orthopedic injuries there. The overwhelming majority of these injuries came as a result of playing football. Basketball was second, baseball was third. We saw occasional injuries in soccer, fencing, track, and even ballroom dancing. The most common area for injury was about the knee, where almost one-quarter of our injuries occurred; second and third were injuries of the ankle and the rib-cage. The range included fractures, dislocations, facial lacerations, abrasions, contusions and many sprains. We had, in addition, several brain concussions. Open surgery was necessary on several severe knee injuries and on severe fractures of the lower leg. Six per cent of our injuries required hospitalization for one or more days. The longest stay was fourteen days. These figures in general agree as to distribution with those of other series at college and high school levels.

Anything we can do to cut down the incidence and severity of injury is certainly important. Let us outline some of the available preventive steps.

Preliminary Examination

First, almost all teams have a physical examination by a physician at the beginning of the season. I wonder if this is enough? I have done these examinations and find that what happens is, that I do 35 or 40 in an afternoon. This must mean that I am checking each boy superficially. I cannot get to know him well. At best, I can hit only the highlights. A physical examination by the team physician is, of course, desirable. At least of equal importance, however, is a good report from each student's family physician: the man who has known this boy since he was small, who knows of all his illnesses and his physical and emotional problems. The family doctor should send his report to the team physician. He ought to cooperate willingly, because a hurriedly filled-out form by an overworked physician may

*Adapted from a talk delivered at Seton Hall University April 2, 1960. This was part of a symposium on athletic injuries sponsored by The Medical Society of New Jersey.

have little value. I suggest that the school system approach the local medical group and work out the questionnaire to be sent to the family physician with them, so that they can publicize to their members, the importance of a complete report.

If this is done, a number of boys, who for one reason or another, should *not* be playing certain sports, will be found who might not be recognized by the superficial physical examination of the team physician.

THE URGE TO WIN

SECOND stage in prevention of injury is the education of the faculty, the students and of the alumnae as to what is the important thing in high school athletics. Everybody wants to win, but frequently too high a price is placed on winning. Within the last year, we had a refracture of a forearm of a high school football player, because this young man was so eager to get back to the game that he returned to football before his fracture was completely healed and before he was medically discharged. Fortunately his second fracture healed satisfactorily. I wonder if it is not too high a price to pay for winning, to suffer a second fracture in the same season?

CONDITIONING THE ATHLETE

THIRD is the proper conditioning of the athlete prior to engaging in an athletic contest. A minimum of two weeks' practice before the first game is desirable. For many boys, this will be sufficient, but for others in poorer condition, certainly two weeks is not enough. One thinks immediately of football. In our own experience at the Montclair State College, we noted a great number of injuries in the early practice sessions and games. Later on, when the boys were in good shape, we had fewer injuries. Preliminary pre-seasoning conditioning during the summer months certainly would have helped a great deal. If it is not sure that conditioning has been practiced by every member of the team, it would seem that members should not be involved in contact sports until later than the conventional two-week minimum period. And, of course, substitutions must be made immediately when there is evidence of player disability.

REVIEWING FOR SAFETY

AN IMPORTANT point is careful coaching, not only to win, but in teaching safe and proper technics of play. After the event is over (especially in football) moving pictures taken during the game, are exhibited to review the play. Among other things, these movies are used to show how an injury took place and discuss how it could have been prevented. There is a "why" to injury, and it is important that each boy learn the "why" so that he can cooperate in preventing injuries.

MONITORING SAFETY

GOOD officiating is necessary, both for a fair game, and for the protection of the players. The correct equipment (the best available) is a minimal requirement of any sport. Not only must correct equipment be obtained, but it must be maintained. Equipment must fit properly. The use of poor or deficient equipment for substitutes, the freshman teams, *et cetera*, is obviously begging for injury.

Good areas of play must be provided, and they must be maintained properly.

DIRECT MEDICAL CARE

ADEQUATE medical care is a necessity, and there should be available at all contests, a physician competent to handle at least the emergency phase of the injuries. He should be available during practice sessions. He is the one to decide whether a player returns to

the game after the injury. Once a player has been out of play for an injury, a written authorization to return to play from the physician certainly is desirable.

For "contact sports," there should be available at the game, a method of transporting any seriously injured player to a nearby hospital in a safe manner. In New Jersey, we are fortunate that volunteer ambulance services are available. They do an excellent job.

ACCIDENT PRONENESS

One of the things that struck me as I reviewed my records, was the number of players who turned up repeatedly with injuries. Over a three-year period, some players were seen more than a half-dozen times. Certainly, there are accident-prone automobile drivers; and I am sure that there are accident-prone athletes. This includes players who do not show good judgment, or "common horse-sense," if you like. Their basic coordination is poor. Others are too small or too light for the particular sport.

In high school, in addition to these, are boys whose physiologic age is behind their chronologic age. Their muscle power, coordination, and "bone age" are slow in maturing. It is dangerous certainly, for any one of these groups to compete interscholastically. There should be a method of breaking these groups down so that pupils can compete with boys of their own general ability. They will have more fun in doing it, and we will have fewer injuries.

FIRST AID

For any major contact sports, a physician should be available *on the field*. He should be interested in and trained to handle injuries. There should also be available a trained first aid squad. In this state, we have many volunteer ambulance groups who do an excellent job. If such an organization is not available, we should consider training our own volunteer first aid group among high school students under coach or teacher supervision.

When such an athletic program is going on, the local hospital should be alerted to the possibility of injuries, so that they may be prepared to handle them. Evening games, for instance, may find the institution without an available x-ray technician unless the hospital is notified that such an athletic activity is going on.

Equipment must be available for this first aid care. The main rule is to keep it simple. None of us in New Jersey lives very far from good medical facilities. Ordinarily, we need do nothing beyond providing safe transportation for a few minutes until full medical care is available. I suggest we use no tourniquets; and no traction splints. A simple "pillow splint" will take care of almost any leg injury. This is effected by wrapping the involved leg in a pillow, and then attaching the extremity to the opposite leg to keep it immobilized, using, if necessary, something as simple as an Ace® bandage.

For an accident to the arm, a very simple splint and a sling will suffice for the vast majority of injuries.

Almost no emergency occurring on the athletic field requires rushing to a hospital at a faster rate than the speed laws allow. The siren-blasting ambulance going through red lights, is almost always unnecessary; and often enough will precipitate a serious automobile accident.

SUMMARY

Here is a recapitulation of methods of cutting down the number of athletic injuries and diminishing the seriousness of those that occur.

1. There must be a team of game officials, coaches and attending physicians dedicated to not only an exciting game, but even more, to a safe game.

2. Each player is entitled to a meticulous physical examination and a complete medical

history prior to being allowed to compete in any school sport program.

3. All players need proper conditioning prior to engaging in competition.

4. Player substitutions should be promptly used when indicated.

5. Moving pictures should be taken and then exhibited to highlight how accidents occur and how they may be prevented.

6. The best available equipment should be furnished to all players, not only to the "varsity" team. Equipment must be maintained properly.

7. Safe and well-maintained play areas are a prerequisite to safe sports.

8. Proper matching of competing players by size, weight and ability is an essential procedure.

CONCLUSIONS

THE winning of the game is desirable. Winning at the expense of the students' well-being is not. A game is played for the sport, for the enjoyment of it, to develop player skills and abilities; to achieve player cooperation and coordination with one another, and it is played to win. But the serious injury of even one player in a game is too high a price to pay for any of these. Student health and safety must be our ultimate goal.

63 South Fullerton Avenue

Varsity Sports: Menace to Our Health?

Writing in the Journal of the Iowa Medical Society (October 1960, vol. 50) R. A. McGuigan charges that the "varsity team system is the principal obstacle to the attainment of physical fitness among adults." Dr. McGuigan argues that: concentration on the star and disregard of the average player results in an increasingly sedentary population. And stressing games from childhood through college that are of no use in adult life does nothing to help this situation."

Dr. McGuigan does not question the importance of sports for children. "No better way is available for the building of muscle coordination or muscular skills." It is the trend toward the *varsity* concept of athletics for children that he deplores. "It produces a hundred spectators for every participant. It produces athletes who devote the formative years of their lives to a sport that they can never pursue in their adult lives. This is the crux of the matter. For there is no reason for the concern about the physical welfare of our children; rather, there is considerable need for thought about our adults."

Body contact sports have serious drawbacks. In Wisconsin, for example, where a state-wide high school athletic insurance program is in force, 6,200 injuries were reported in the 1958 season. Football accounted for two-thirds of the total insurance costs incurred. From 1931 through 1959 there were 491 fatalities directly due to football; 387 were in boys of high school age or below.

The greater susceptibility of the pre-adolescent to serious traumatic injury "is unquestioned," the author said. It is foolhardy "to subject a growing child deliberately to activities of the strenuous, body-contact kind, knowing that . . . the joints (are) poorly protected by stabilizing and protective muscle, ligament and tendon, the coordination insufficiently developed, and the skills imperfectly established."

Dr. McGuigan suggests that the years prior to 12 be devoted to games that will develop basic skills and to developing the habit of good sportsmanship.

"The idea should be to have as many children playing as many different games as possible. Emphasis should be in the direction of a program that will produce as many adult *participants* and as few adult *spectators* as possible in future years."

Ariad G. Gerard, M.D.

Woodbridge

Subdermal Infiltration of Triamcinolone Diacetate Suspension in Different Dermatoses

Good results are reported in a number of dermatoses by the use of a suspension of triamcinolone diacetate.

An effective new technic in the treatment of 19 cases of psoriasis, which I reported previously,[1] was affirmed recently in a report by Pelzig and Baer.[2]

Subdermal infiltration of the psoriatic lesion in the upper layer of the loose subcutaneous tissue with a 0.25 per cent suspension of triamcinolone diacetate† (2.5 milligrams per cubic centimeter) cleared locally the psoriatic lesions in less than 10 days. The skin returned to its normal appearance. The response of the lesions was uniform.

My first patient had eczematous contact dermatitis of the hand (due to x-ray developer) superimposed upon the original psoriatic lesion. Subdermal injections cleared up both conditions simultaneously. This observation prompted me to a clinical study of 26 varied cases of localized subacute and chronic dermatoses.

Although the cases are not numerous, the remarkable and uniform results justify this report.

†The suspension of triamcinolone (Aristocort®) diacetate, was supplied by Christopher H. Demos, M.D., of Lederle Laboratories, Pearl River, N. Y.

1. Gerard, A. G.: A.M.A. Archives of Dermat., 81:535 (1960).

2. Pelzig, A. and Baer, R. L.: J.A.M.A., 173:898 (1960).

MATERIALS AND METHOD

One-quarter of one per cent triamcinolone diacetate† (2.5 milligrams per cubic centimeter) suspension was obtained by mixing 10 parts of the commercially available concentrated triamcinolone diacetate (TD) suspension (25 milligrams per cubic centimeter) with 45 parts of normal saline and 45 parts of 1 per cent procaine. To obtain a homogenous suspension, the syringe is turned a few times. A few minims of 1 per cent procaine is injected with a 26 gauge 3/8-inch long needle at the periphery, beyond the lesion if it is oozing, fissured or tender. Then the suspension is infiltrated without pressure subdermally under the lesion in the upper layer of the loose subcutaneous tissue with an appropriate needle. For a lesion of 25 millimeters in diameter, a 2 cubic centimeter suspension was sufficient. A larger amount was used, according to size of lesion. Several lesions may be treated simultaneously. I have never used more than 10 cubic centimeters per treatment and per week.

RESULTS

Twenty-six patients with 9 types of localized subacute and chronic dermatoses were treated. They were selected for the treatments

because their response to more conventional measures (including topical steroid medication) was unsatisfactory or because they were not responsive at all. These types of skin diseases often do respond to some form of steroid therapy.

Results are summarized in the accompanying table.

All the treated lesions in these cases, disappeared completely, or regressed. The effect of the steroid was limited only to the areas so treated. The consistency with which the improvement occurred, was unusual. The itching, whenever present, was relieved even before the involution of the lesions. At the present no recurrences were seen. In all these cases 0.25 per cent TD suspension was used exclusively.† My impression was that a weaker suspension would have been effective in many of the cases. Large lesions needed several weekly injections to cover the whole area. No lesion needed repeated injections excepting pruritus ani; there 3 and 4 weekly treatments were needed to control it. In the one case of eczema, two weekly injections were necessary.

No local, nor systemic side effects were observed.

Cases	Years Duration	RESPONSES Excellent	Very Good	Poor
6 Neurodermatitis	1 to 8	6	0	0
1 Granuloma annulare	8 months	1	0	0
2 Housewife's eczema	1 to 5	2	0	0
2 Eczema, unspecified	1 to 2	2	0	0
3 Adult atopic dermatitis	2 to 7	2	1	0
5 Contact dermatitis	1 to 4	5	0	0
3 Intractable pruritus ani	1 to 4	2	1	0
2 Pruritus genitalis	1 & 5 mos.	2	0	0
2 Numular eczema	2 & 3 yrs.	2	0	0
26		24	2	0

Note: Kern 3 has reported involution of granuloma annulare lesions by intra-lesional placebo injections. In the atopic dermatitis group, two of the three patients had also been taking steroid medications. In one of the cases of contact dermatitis, residual scaling persisted for two weeks. In one patient with pruritus ani, his response was so satisfactory after two injections that he discontinued further treatments. The others received injections for 4 weeks.

DISCUSSION

ACCUMULATING experience and observations indicate that treatment of psoriasis and other dermatoses with subdermal infiltration of 0.25 per cent triamcinolone diacetate suspension in the upper layer of the loose subcutaneous tissue is a valuable mode of therapy. The good effect is not necessarily dependent on the continuous presence of the hormone but rather on a higher concentration for a short period of time.

The mechanism of action of the steroids in skin diseases is not well understood. A theoretic interpretation is possible by Selye's "stress theory"[4] and his description of the "diseases of adaptation." Since the skin is predominantly a connective tissue and a blood vessel organ, it is to be expected that in many skin disorders at least the upper layer of the subcutaneous tissue is involved and develops an insufficient or abnormal adaptive reaction. With the administration of the stress hormone locally, "this stage of exhaustion terminates and with this emergency adjustment the skin relearns the defense against future exposure to stress and helps to maintain a state of adaptation once this is acquired."[4]

SUMMARY

TWENTY-SIX patients with 9 types of dermatoses, other than psoriasis, were treated with subdermal infiltration in the upper layer of the loose subcutaneous tissue with 0.25 per cent suspension of triamcinolone diacetate.† All the treated lesions were cleared up completely or regressed in less than 10 days. No relapse occurred in these treated cases during the observation period up to 12 months.

The remarkable and uniform results obtained in different dermatoses should make this technic a common practice in dermatology and in selected cases, the first choice of treatment.

3. Kern, A. B. and Schiff, B. L.: A.M.A. Archives of Dermat., 81:969 (1960).

4. Selye, H.: *Stress,* Acta, Inc. Publ. Montreal, Canada, First Edition (1950).

502 Rahway Avenue

Jack R. Karel, M.D.

Elizabeth

Civil Defense

A Training Program for Allied Medical and Health Personnel

Dr. Karel is Chairman of the Civil Defense Committee of the Union County Medical Society, Medical Coordinator, Union County Civil Defense and Disaster Control, and Member of the Special Committee on Disaster Medical Services of The Medical Society of New Jersey.

World conditions during the past year have brought the United States to probably its most critical period in its long history as a free nation. These conditions have been brought about by an aggressive Communistic and atheistic philosophy that does not believe in the American way of life. We are placed in a position whereby we must be strong eternally and maintain our strength so that our efforts will be the greatest deterrent to aggression by our potential enemy. We are at a place where we must make an honest appraisal and reach a decision. We must undertake a period of constructive action for the betterment of medicine during any disaster that may come.

In this nuclear age we have learned that in any great disaster due to enemy action the disparity between the number of casualties and the number of physicians who will be available is tremendous. Therefore, we need all professionally trained people, such as dentists, veterinarians, pharmacists, nurses and so on, to do as much as they are able and capable, when and as called upon. It is most imperative that:

1. All physicians, regardless of their specialty, receive training and become proficient in the practice of disaster medicine.

2. Dentists become proficient in the practice of disaster dentistry; and additionally receive such training in disaster medicine as will enable them to take effective lifesaving and first-aid measures and assist the medical profession by performing additional functions.

3. All personnel receive instructions in the casualty producing effects of mass weapons, passive defense measures and sanitation, to the end that they may protect themselves from preventable injuries in the event of all-out war.

Most members of the dental profession can perform, under certain general medical supervision, most of the following additional functions:

1. First aid, including but not limited to artificial respiration, emergency treatment of open chest wounds, relief of pain, treatment of shock and the preparation of casualties for movement.
2. Control of hemorrhage.
3. Attainment and maintenance of patent airway and intratracheal catheterization, to include tracheotomy.
4. Proper and adequate cleansing and treatment of wounds.
5. Bandaging and splinting.
6. Administration of anesthetics under medical supervision.
7. Assisting in surgical procedures.
8. Insertion of nasogastric tubes to include lavage and gavage as directed.
9. Administration of whole blood and intravenous solutions.
10. Administration of parenteral medications, as directed.
11. Catheterization of males and females.

12. Administration of immunizing agents, as directed.
13. Triage of facial and oral injury cases, including oral surgery.
14. Definition of Triage (Sorting):

a. Priority I—Those requiring out-patient care only.

b. Priority II—Those moderately injured and ill whose chances of recovery are good following immediate treatment.

c. Priority III—Those injured and ill whose chances of recovery are not jeopardized by delayed definitive treatment.

d. Priority IV—Those critically injured or ill who require extensive, complicated, time-or-material-consuming procedures and those who are beyond help.

All of these training objectives have been endorsed in the National Defense Program by the American Medical Association and the American Dental Association.*

In Union County we are establishing a training program for allied medical and health personnel to reduce the disparity previously mentioned. We urge all counties in New Jersey to take similar action.

The subjects being covered by competent specialists in our program will be as follows:

1. Triage (Sorting) and General Medical Principles
2. Shock and Hemorrhage
3. Orthopedics
4. Ophthalmologic Injuries
5. Thermal Injuries
6. Fallout Radiation and Radiation Injuries
7. General Surgery
8. Oral and Maxillo-facial Surgery

*Summary Report on National Emergency Medical Care, American Medical Association, Oct. 1959.

407 Jersey Avenue

Life Expectancy Going Up

The average infant born in this country today can expect to live half-again as long as one born in 1900, Health Information Foundation reported in its December 1960 statistical bulletin, *Progress in Health Services.*

Life expectancy shows for a given time-period the average lifetime to be expected by a population if at each successive age it experiences the mortality rates prevalent during that time-period.

A baby born in 1900, H.I.F. said, could expect to live 47 years, while one born in 1960 has a life expectancy at that time of 70 years —the highest ever recorded in this country for the total population.

Both males and females have benefited from increasing life expectancy. Greater gains have been made by females. While life expectancy for males rose from 46 years in 1900 to 66 in 1958 (a gain of 20 years), the comparable rise for females was from 48 to 73 (a gain of 25 years).

Social consequences arising from the trend toward longer life include: a record growth in the number of aged persons, an increase in the working lifetime of the average person, a decline in the number of orphans, and a postponing of widowhood to the later years. The great majority of parents today will not only live to see their children grow up, but can also look ahead to some reasonably active later years. One reason for the extension of life is that the infective and parasitic diseases, which once decimated those at the younger ages, have now been so largely controlled. This class of diseases caused 18 per cent of the deaths in 1900. Today it causes just 1 per cent.

The application of new medical knowledge has imposed on the public "the need for greater investment in public health measures and greater use of physicians, hospitals, drugs, and all components of medical care. Each new breakthrough requires a larger investment by the public if that knowledge is to be converted to longer life and more comfort to those living with illness."

Trustees' Meeting: December 18, 1960

At its December session, our Board of Trustees took the following actions.

It received a report from the State Board of Mental Health Commission that it was ready to submit its final draft of the proposed mental health code. The recommendations made by our Society have been appreciated and are being given serious consideration.

Dr. Fred B. Rogers, our archivist and chairman of our Publication Committee, was named to attend the December meeting of the American Medical Writers' Association, representing the President.

BLUE SHIELD RATE INCREASE

For the purpose of building up its depleted reserves, Blue Shield has applied for a premium rate increase of 23 per cent. Labor has recorded itself as opposed to the request, and has announced that it will operate its own plan, similar to New York GHI plan, in competition to Blue Shield with full coverage payments at, apparently, lower rates than Blue Shield.

NEW JERSEY WELFARE COUNCIL

The Trustees authorized the payment of $25 dues for 1961 Society membership in the New Jersey Welfare Council.

SAFETY COUNCIL

At the request of the President, the chairman of the Special Committee on Traffic Safety, Dr. A.M.K. Maldeis, attended the meeting of the New Jersey State Safety Council on November 28, 1960. Dr. Maldeis reported:

The Council displayed a trophy which had been won by New Jersey for its achievement in the safety program. Approval of a possible source of funds for a safety study being made by Seton Hall College of Medicine was voted. A very interesting address was given by Mr. Russell I. Brown, President of the Insurance Institute for Highway Safety, Washington, D. C.

The report was received and noted, and the President was requested to thank Dr. Maldeis for his attendance in behalf of the Society.

NATIONAL LIBRARY COMMITTEE

An invitation was received and accepted by Dr. McCall to serve on the Committee for National Library Week. The Board indicated its approval of Dr. McCall's acceptance of membership on the Committee.

CHEMOTHERAPY IN TUBERCULOSIS

At the October Conference on Chemotherapy in Tuberculosis, minimum standards of chemotherapy were recommended. These standards will be printed by the Association and distributed to all New Jersey physicians. See page 76 of the February 1961 issue of THE JOURNAL.

REPORT OF EXECUTIVE COMMITTEE

In accordance with the Board's directive at the November meeting, legal counsel prepared "Comments and Recommendations concerning Presentment P6 M-59 of the Union County Grand Jury," which were approved by the Executive Committee and then submitted to the Legislative Commission Investigating Blue Cross. For information purposes, copies of the comments and recommendations were distributed to the Trustees, Secretary of the State Board of Medical Examiners, and the Secretary and Executive Secretary of the Union County Medical Society.

Dr. Greifinger moved—seconded by Dr. Kaufman and carried—that the action of the Executive Committee be confirmed.

Mr. Backes reported that he and Mr. Nevin had both reviewed the Maryland Survey, and that both felt it would be inappropriate to make any comment. It is a detailed survey, of interest and information properly to physicians and other citizens of Maryland but, in their view, not an item on which the Board or the Society should make comment.

Dr. Allman moved—seconded by Dr. Kaufman, and carried—that the report of counsel be accepted.

MEDICAL POLITICAL ACTION COMMITTEE

A communication from the AMA Council on Legislative Activities reported the council's interest in the political activities of physicians and committees of physicians during the 1960 Presidential campaign, and requested the opinion of the State Society concerning the advisability of creating a National Medical Political Action Committee.

Dr. Allman and Dr. Blaisdell, both members of the council, stated that such a committee would be outside the realm of organized medicine. Reference was made to an interprofessional committee in Michigan, composed of doctors, dentists, lawyers, engineers. Such an organization as is proposed must, for tax reasons, be outside the structure of organized medicine.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that the Society's representatives on the AMA council report orally to the council at its next meeting on what was done in New Jersey by way of political action by physicians in the recent campaign.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that the Secretary of the AMA council be notified that this Board approves in principle establishment of a National Political Action Committee provided that adequate safe-guards are employed in connection with it.

MEDICAL CARE AND LABOR

In a communication to the Executive Officer from the President of the State CIO Council, Joel R. Jacobson, it was suggested that a joint meeting be held between representatives of labor unions and representatives of the medical profession of New Jersey to discuss areas of common interest.

Mr. Nevin reminded the Board that a few years ago the Society suggested to representatives of the AFL-CIO and of industry the establishment of a liaison committee for the purpose of discussing matters of common interest. In acknowledging receipt of Mr. Jacobson's suggestion, this fact was noted.

The Board agreed that a joint meeting should be held. Dr. Allman then moved—seconded by Dr. Featherston, and carried—that the invitation for a joint meeting be accepted, that our Executive Committee serve as our representatives and that Industry also be invited to send representatives.

REPORT OF AMA DELEGATES

The report* of the AMA Delegates, covering activities at the 1960 clinical session, was accepted—upon motion by Dr. Kaufman, seconded by Dr. Wegryn, and carried.

Dr. Blaisdell reported that the delegates had agreed that they should get together and analyze the developments of the actions of the AMA House of Delegates—in particular with reference to the impact of its actions upon what The Medical Society of New Jersey is doing and what it will be asked to do. Dr. Costello indicated such a conference would have been held if it were not for the inclement weather and the early meeting of this Board.

At the Washington clinical session, the New Jersey officers and delegates and their wives had a dinner party in honor of the retiring delegates, Dr. Hurff and Dr. Weigel, as an expression from The Medical Society for their long service as delegates. The expense of the dinner, which amounted to less than $150, was not provided for in the budget.

Dr. McCall reported that he had received "thank you" letters from both Dr. Hurff and Dr. Weigel.

Dr. Greifinger moved—seconded by Dr. Bowers, and carried—that the Board approve that the expense incurred in connection with the dinner be paid by the Society.

COUNCIL ON PUBLIC HEALTH

The Council on Public Health met on December 7, 1960. The following actions of the council are referred to the Board of Trustees for action:

VACCINIA IMMUNE GLOBULIN (V.I.G.)

Through Dr. Dougherty of the State Department of Health, the council received and considered a suggestion that the American Red Cross pamphlet "Vaccinia Immune Globulin (V.I.G.)" be distributed to the members of the Medical Society.

Recommendation: That the information contained in the American Red Cross pamphlet, Vaccinia Immune Globulin (V.I.G.), announcing a new blood product for treatment of complica-

* See page 118 of this JOURNAL.

tions of vaccination which is available to physicians through the Blood Program of the American Red Cross, be disseminated to the membership through publicity in THE JOURNAL of The Medical Society of New Jersey.

Upon motion by Dr. Ware—seconded by Dr. Greifinger, and carried—the recommendation was approved.

CHILD HEALTH

The following recommendation of the Special Committee on Child Health was adopted:

To inform the membership of the Society of the importance of the role of the school physician, it is recommended that an exhibit on "The Changing Role of the School Physician" be prepared and presented by the special committee at the 1961 annual meeting next May in Atlantic City; and that an appropriation not to exceed $100 be made to meet the expense of preparing and presenting the exhibit.

Dr. Blaisdell moved—seconded by Dr. Ware, and carried—that the recommendation be approved, and that the cost of the exhibit be charged to the budget appropriation of the Council on Public Health.

CONSERVATION OF VISION

The following report and recommended program were approved by the council:

Believing that no school eye health program could be effective unless ophthalmologists were available to do the work necessitated by such established programs, approval was given the following procedure as an attempt toward gaining the cooperation of all ophthalmologists in the State:

Suggested letter to all New Jersey ophthalmologists should read: "A program is being developed to supervise eye health care in your local schools. This does not require your doing the actual work. We plan to have workshops on eye-health care in each county. We must have ophthalmologists available for these workshops. Please signify your willingness to cooperate in this important program on the enclosed reply postal."

A letter would be sent to county medical society presidents requesting assistance in having local ophthalmologists set up workshop programs on the eye health care of the school child.

Eye physicians signifying willingness to conduct workshops to be informed in detail on:

1. How to conduct a workshop
2. How to set up an eye health program in a school; and
3. Whom to contact for these purposes.

Dr. Allman moved—seconded by Dr. Jehl, and carried—that the Special Committee on Conservation of Vision be authorized to proceed with the recommended program.

HEARING AND SPEECH

The following *recommendations* from the Special Committee on Conservation of Hearing and Speech were adopted:

(A) That a Hearing and Speech Research Department be established to be composed of those hearing and speech centers that so desire to become a part of the research department.
(B) That application be made for a research medical grant through the National Institute of Health.

Dr. Kaufman moved—seconded by Dr. Greifinger, and carried—that the recommendations be approved in principle on the condition that the Medical Society be not involved.

COUNCIL ON LEGISLATION

A regular meeting of the Council on Legislation was held at the Executive Offices on December 11, 1960. Following is a summary report of the significant actions taken at that meeting:

NEW DEFINITION OF CHIROPODY

Present during this discussion with the council were representatives from the New Jersey Orthopedic Society, the Radiologic Society of New Jersey, and the New Jersey Chiropodists Society. These representatives were present to consider proposals by the chiropodists concerning the definition of chiropody. These proposals were submitted in consequence of the November 3 meeting with the Executive Committee and of the chiropodists' recognition of the fact that The Medical Society of New Jersey would oppose the added elements in S-266. The following six items represent the minimal changes in the definition which the chiropodists would like to obtain. They are less extensive than those contained in S-266.

(1) Treatment of osteomyelitis of the phalanges due to local infectious origin;

(2) Tendon transplantations in the area of the metatarsophalangeal joints;

(3) Bone resections;

(4) Simple fractures of the metatarsal bones and phalanges;

(5) Dislocations of the metatarsal and phalangeal joints;

(6) Treatment of congenital deformities by use of a cutting instrument or electrosurgery.

No final conclusion was reached with reference to these items, because it was the conviction of the council that further detailed investigation should be made concerning the adequacy of the training afforded graduates in schools of chiropody.

The representatives of the New Jersey Orthopedic Society were requested to take back to their executive committee the new proposals of the chiropodists and, having studied them, to submit to the Council on Legislation recommendations concerning their acceptability.

The council also agreed to *recommend* that the State Board of Medical Examiners consider the advisability of a joint inspection, with representatives of the council, of the Ohio College of Chiropody, in accordance with the invitation to do so extended by the Dean of the College at the time of his participation in the meeting with the Executive Committee of The Medical Society of New Jersey on November 3.

The chiropodists were eager to have definite action from The Medical Society of New Jersey as soon as possible so that, should agreement not be reached concerning the new proposals, S-265 in its original form might be reactivated in the New Jersey Legislature.

The chairman of the council made no commitment as to a time deadline—pointing out the necessity for further detailed investigation to determine the adequacy of the training of chiropodists—but he did assure them that the Society would proceed to its decision with all possible speed, and that contact would be made with them regarding the next step following the meeting of the Board of Trustees on Sunday, December 18.

Dr. Bowers moved—seconded by Dr. Buchanan, and carried; Dr. Featherston voting in the negative—that representatives be sent to the Ohio College of Chiropody, that such information be conveyed to the State Board of Medical Examiners, and that the Society representatives go contingent upon the State Board likewise sending representatives.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried; with Dr. Jehl, Dr. Allman, Dr. Buchanan, and Dr. Featherston voting in the negative—that the expenses of three representatives be paid by the Medical Society and be charged to the budget of the Council on Legislation.

STATE LEGISLATION

A-699 *Williams, Franklin, Martin*—to regulate the furnishing of public medical services through county welfare boards under the supervision of a new Bureau of Public Medical Services in the Division of Welfare of the Department of Institutions and Agencies — *Approval*

The council considered the detailed report of the Legislative Analyst concerning this legislation, and unanimously *recommended* the approval of A-699.

Dr. Kaufman moved—seconded by Dr. Ware, and carried—that the recommendations of the council on A-699 be approved.

Dr. Kaufman moved—seconded by Dr. Greifinger, and carried—that the report of the Council on Legislation as a whole as amended be accepted.

INTERNATIONAL COLLEGE OF SURGEONS

The Atlantic City Convention Bureau reported that invitations are being issued to the International College of Surgeons to hold its 1965 convention in Atlantic City. The Medical Society of New Jersey was requested to issue an invitation to the College on behalf of Atlantic City.

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that a letter of invitation be sent to the International College of Surgeons to hold its 1965 convention in Atlantic City.

1961 ANNUAL MEETING

As chairman of the Committee on Annual Meeting, Dr. Kaufman recommended that (subject to the acquiesence of the Council on Public Relations) the February, 1961, issue of the Membership *News Letter* be assigned to the Committee on Annual Meeting for publication of the advance program of the 1961 annual meeting with the additional printing and mailing charges to be assumed by the Committee on Annual Meeting.

Dr. Greifinger moved—seconded by Dr. Bowers, and carried—that the recommendation be approved.

PROFESSIONAL LIABILITY INSURANCE

Dr. Featherston, chairman of the Committee on Medical Defense and Insurance reported on the increase in rates for liability insurance under the new program of the American Liability Insurance Company:

National Bureau rates for the medical profession are used by most stock insurance companies and were changed about October 5, 1960. The important changes, which were state-wide, were increases of approximately 37 per cent for surgeons and employed surgeons and a decrease of approximately 34 per cent for the use of x-ray therapy.

Rates are changed with approval of the Department of Banking and Insurance of New Jersey based on statistics of loss experience which include actual payments plus reserves for open cases of the insurance companies in this state.

The new program of Professional Liability Insurance as endorsed by the House of Delegates in 1960 included a provision that the American Mutual, with no loss experience in New Jersey, would use the National Bureau rates until actual experience would justify the filing of rates showing any deviation. Therefore, the American Mutual has changed its rates effective December 13, 1960. In a few years, we hope to consult with the American Mutual and establish rates which will be more equitable for the many members of our Society and such rates to be based only on the experience of the insured members of the Society under the endorsed program.

MEDICAL EDUCATION AND LICENSURE

The annual conference of the AMA Council on Medical Education and Hospitals, followed by the annual meeting of the Federation of State Medical Boards, will be held in Chicago in February, 1961.

Dr. Buchanan noted that, with the exception of the past few years, a representative from The Medical Society of New Jersey had been appointed to attend these annual sessions. He suggested that the Board consider sending a representative to the 1961 sessions.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried—that Dr. Allman be appointed as the Society's representative to the 1961 Chicago conferences on medical education and licensure.

AMA Interim Meeting*

The AMA Interim Washington meeting drew a total registration of 3,940 physicians and 4,239 guests. Reports indicate a very good clinical program, well attended. Discussion created the impression that the exhibits were not as well patronized as exhibitors had hoped.

Among the problems most discussed were: anticipated dues increase, care of the aged, foreign graduates problem, improved and promotion of voluntary health insurance, problems in relation to industrial workers, improved conditions in nursing homes and student loan program.

FOREIGN GRADUATES

Hospitals are encouraged to develop educational programs to improve the ability of these graduates to take examinations. Those who failed are eligible for re-examination in April, 1961, working in hospitals meanwhile, but having no direct patient care responsibilities.

SCHOLARSHIP AND LOAN PROGRAM

To encourage more students to enter medical school as against the present tendency to enter other fields, a program of scholarship and loans was proposed. It was well received and endorsed. The participation by individual physicians, county and state societies is solicited.

AMA DUES INCREASE

The Board of Trustees announced that a dues increase of from $10 to $25 would be requested in June, 1961, to take effect in January, 1962. The reference committee proposed a graduated increase of $20—a $10 increase to be effective on January 1, 1961, and a sec-

*Report prepared by Dr. William F. Costello.

ond $10 increase to be effective on January 1, 1963, and thereafter. The funds, the House suggested, should be used to establish or expand:

1. Financial aid to students.
2. Continuing education for practicing physicians.
3. Health advice to the public.
4. Medical research.
5. Expansion of the communication division of the AMA.

VOLUNTARY HEALTH INSURANCE

The Board of Trustees report and many resolutions on this subject evoked considerable discussion. The reference committee presented, and the House adopted, the following substitute resolutions:

Whereas, the public has shown its confidence in this voluntary system; and

Whereas, current social, political and economic developments compel a new and revitalized effort to make voluntary health insurance successful; and

Whereas, the American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

Resolved, that the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association and the Blue Cross Association into maximum development of the voluntary, non-profit prepayment concept to provide health care for the American people; and be it further

Resolved, that similar leadership be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

Resolved, that, where feasible, efforts be made to cooperate with representatives of other types of medical care plans, other professional groups and representatives of industry, labor and the public at large.

HEALTH CARE FOR THE AGED

Reaffirmation of support of Kerr-Mills Bill and firm opposition to the use of OASDI for medical support to the aged was stressed. State and local medical organizations are exhorted to cooperate with state officials in implementing the provisions of the Bill.

NURSING HOMES

For the past three years the Council on Medical Service has made a study of nursing homes and urges that increasing recognition be given to develop more medical supervision, training of personnel, and improved vocational and rehabilitation programs.

INDUSTRIAL WORKERS PROGRAM

Discussion of this problem was provocative of some heated debate. Opposition was developed as to any change and the Committee was directed "To carry out its duties as previously instructed and to prepare its guides in conformity with the clear cut policies already laid down by the House of Delegates."

OSTEOPATHY

New Jersey Resolution 23 in reference to this question was referred to the Judicial Council for discussion in conjunction with a progress report of the Liaison Committee of Medical Society and Osteopathic groups.

OTHER MATTERS

Many other matters were acted upon which will be reported in the *Journal of the American Medical Association*. We recommend that members follow these articles.

Your delegates regret the illness of Dr. Aldrich C. Crowe, which prevented his attendance. However, his place was ably filled by Dr. Elton W. Lance. All sessions were attended by our full complement of delegates.

Your delegation regrets the fact that two members distinguished for long and able service represented The Medical Society of New Jersey for the last time at this session. Dr. Elmer P. Weigel and Dr. J. Wallace Hurff served on many reference committees and were always prompt and conscientious in attendance. They deserve a note of appreciation from our membership.

The administration of our headquarters accommodations was well handled, after some early hotel problems were adjusted.

Announcements

Social Aspects of Arthritis

You are invited to participate in an unusual panel discussion on Thursday evening, March 30, 1961. This will be a presentation of social, emotional and cultural aspects of arthritis. The meeting will start at 10:30 a.m. and the $2.50 registration fee includes a luncheon. The panel consists of a sociologist, an anthropologist and a rheumatologist. Dr. Lamont-Havers will be the moderator. The meeting will be held in the Baldwin Avenue building of Seton Hall College of Medicine in Jersey City. For further details, write to Arthritis Unit, Surgical Section, Seton Hall College of Medicine, Jersey City 4, N. J. Checks should be payable to Marian Wied.

Graduate Courses in New York

Special graduate courses for medical practitioners are announced by New York University as follows:

Management of the Patient with Allergy. Friday afternoon, starting April 7. Tuition: $45. Ask for course 5410.

Gynecologic Endocrinology. Full time, morning and afternoon, April 17, 18, 19, 20 and 21. Tuition: $140.

Ophthalmoscopy. Five consecutive mornings starting April 17. Tuition: $60.

Pediatric Surgery. Three mornings, three afternoons, May 4, 5 and 6. Tuition: $75.

Modern Dermatology. Full time, May 8, 9 and 10. Tuition $75.

For details, write to N.Y.U. Post-Graduate School of Medicine, 550 First Avenue, New York (16) N.Y.

Audiology Course

A "Short Course in Audiology" will be presented by Temple University Hospital on June 19th through 23rd, 1961. For further information, write to Section on Audiology, Temple University Medical Center, 3401 North Broad Street, Philadelphia, Penna.

V. D. Seminar

Monday, Tuesday, and Wednesday, April 10, 11 and 12, have been set aside for a venereal disease seminar in New York City at the Hotel New Yorker. Sponsored by the U. S. Public Health Service and various State Health Departments, this colloquium is programmed as follows:

Monday, April 10: *Morning*—The Status of Syphilis Today.

Monday, April 10: *Afternoon*—Panel on "The Society We Live In," moderated by Bergan Evans, discussing urbanization, sex, salesmanship and the arts.

Tuesday, April 11: *Morning*—Problems of Children and Youth.

Tuesday, April 11: *Afternoon*—V.D. Control.

Wednesday, April 12: *Morning*—Management of Syphilis.

Wednesday, April 12: *Afternoon*—The Future of V.D. Control.

For further details, write to The Commissioner of Health, State Health Department, Trenton 25, N. J.

Register Your X-Ray Machine

Under the law it is necessary to register not only x-ray machines and fluoroscopes, but also particle accelerators, electronic microscopes, and all equipment that produces radiation. For further details write to Dr. Roscoe P. Kandle, Commissioner of Health, at the State House, Trenton, N. J.

Involution of Aging Man

The National Library of Medicine has a bibliography on "Physiologic Involution in Aging Man." Copies may be obtained gratis from the Acquisition Section, National Library of Medicine, Washington 25, D. C.

Graduate Courses in Philadelphia

The week beginning April 18, 1961 is the season for County Medical Society's intensive graduate program in Philadelphia. Topics to be covered include emotional aspects of physical disease, stress and the steroids, common surgical problems, social and educational problems of medicine, lesions of the genital tract and portal hypertension. The institute is accepted for Category I credit by the American Academy of General Practice. Registration fee of $10 will cover all courses. For details, write to Dr. Malcolm Miller, 301 South 21 Street, Philadelphia 3, Pa.

Recent Advances in Nutrition

Monday evening, April 24, has been set aside for a seminar on modern nutrition. Sponsored by the Medical Society of New York County, the colloquium will begin at 8:30 p.m. at the Barbizon Plaza, at 100 Central Park South in New York City. Professor R. E. Olson will open the program with a discussion of nutrition and cardiovascular disease. Paul Gyorgy—chief of pediatrics at Philadelphia General Hospital—will talk on nutrition and blood dyscrasias. The final paper on the abuse of vitamins will be read by William Henry Sebrell, director of Columbia University's Institution of Nutrition. Time is set aside for comments and questions. For further details, write to New York Medical Society at 750 Third Avenue, New York, N. Y.

Review of Medical Movies

The latest edition of the annual *Reviews of Medical Motion Pictures* is now available upon request. It contains all of the reviews published in *The Journal* of the American Medical Association during 1960. This material provides a brief description and an evaluation of motion pictures available to the medical profession. Every effort is made to publish frank, unbiased comments. For your copy, write to American Medical Association, Department of Medical Motion Pictures, 535 North Dearborn Street, Chicago 10, Illinois.

Honor to Mary Bacon

At the January 17 meeting of the Bridgeton Hospital Staff, Dr. Mary Bacon was made an Honorary Member. This recognition, according to the Hospital By-laws, is conferred for 'attainments and service to the profession." It is not to be confused with emeritus membership (which is conferred on completion of an established period of service). Dr. Bacon was the first, and to date, the only woman physician to have been Chief-of-Staff of the Bridgeton Hospital.

Currently, she is Chairman of the Hospital Prenatal Committee. Bridgeton Hospital on January 1, 1961 was accepted as one of the one hundred hospitals in the U.S.A. to carry out a pilot study in perinatal mortality, a project of the Research Foundation of the American Medical Association.

New Cook Book for Weight Watchers

Announcement is made of a special cook book for appetizing but low-calorie meals. Physicians may obtain free copies by asking for the "Cook Book for Weight Watchers," writing to P.O. Box 777, Hinsdale, DuPage County, Illinois.

For Your Traveling Patients

The U. S. Government Printing Office has available at nominal prices a number of health hints for tourists. The material covered includes vaccinations needed, common diseases, special tips for people with chronic illness, special health problems of each area, information on diet and so on. The brochures are identified as follows:

PHS Publication 748A—"So You're Going Abroad"
PHS Publication 748B—"Health Information for Travel in Mexico, South America and the Caribbean"
PHS Publication 748C—"Health Information for Travel in Asia, Indonesia, Australia and the Philippines"
PHS Publication 748D—"Health Information for Travel in Africa"

These brochures sell at 5 cents each or $3.75 a hundred. Copies are obtained by writing to Superintendent of Documents, Government Printing Office, Washington 25, D. C., and asking for the indicated Public Health Service publication.

County Society Reports

Bergen

The regular meeting of the *Bergen County Medical Society* was held January 10 at Bergen Pines Hospital, Paramus. There were 66 members present.

The following were elected to membership: *To Active*—Felix Joseph Venutolo (from Hudson County Medical Society), John Gordon Bell, Jr., Alfred Del Vecchio, Richard Patrick Gilligan; *To Associate*—Martha R. B. Adams, Claudio Maurizio Castelli, Robert H. Glick; *To Emeritus*—Lloyd B. Whitman; *Leave of Absence*—Maurice Golbey.

Dr. Phoebe Hudson, Chairman of our School and Child Health Committee, announced that a public seminar on school health procedures and minimum standards for school health services sponsored by the Bergen County Medical Society, will be held at the Garden State Plaza Auditorium on Saturday afternoon, March 4, 1961.

Dr. R. Keating, Chairman of the Program Committee, introduced the speaker, Dr. Frank G. Dunnington, Professor of Physics, Rutgers University. The Professor gave an interesting dissertation on "Perspective on Fall-Out." After describing the four principal types of rays—alpha, beta, x-ray, gamma—which cannot be detected by human senses but minute quantities of which can be picked up by instruments, he described their somatic and genetic effects on man. Dr. Dunnington presented statistics indicating that the amount of radiation of Strontium 90 and Cesium 137 absorbed by the human body from man-made radiation was far below that received from natural sources. This showed that the sum of the dosages received from both man-made and natural sources was far below the permissible limits allowed. Therefore, as of this date radiation from fall-out has caused no appreciable body injury. The Federal Radiation Council recently stated that in prescribing the use of any form of radiation-producing equipment, the potential good to be derived from the exposure must be carefully weighed against possible exposure damage. At the conclusion of his remarks, Dr. Dunnington graciously answered many questions and was warmly thanked by the Chair and the Program Chairman for his very informative lecture.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

The *Burlington County Medical Society* convened in regular session at the Millside Farms Dairy Bar, Route 130, Riverside, N. J., on January 12, with 42 members and 9 guests. President Boudwin called the meeting to order at 8:03 p.m.

An excellent dissertation on "Ulcerative Colitis —Medical and Surgical Management" was presented by James L. A. Roth, M.D. and Alfred S. Frobese, M.D., and evoked an interesting discussion period following their presentation.

Guests were introduced: From McGuire Air Force Base we had Drs. T. R. Downey, W. W. Phalon, R. J. R. Byrne, J. R. Hewson, and L. L. Keeler; Burlington County Hospital Residents, Drs. Adriano, Santos and Halgado; and Dr. June E. Greenspan, an applicant for associate membership in our Society.

Dr. Mulford, member of the Nominating Committee, presented their panel of candidates for the year 1961-1962.

At The Medical Society of New Jersey May 1961 Annual Meeting, it was agreed that we would rent hotel accommodations in the same manner as for the 1960 convention.

Drs. Messey, Muir and Comerci, who had been elected to Associate membership at our December meeting, were presented to the Society, took the oath of membership and signed the Constitution.

Announcement was made that the psychiatric seminars of the Children's Hospital were being held every other Wednesday. Our Dr. Harrington is on this panel. A former member, Dr. Brashear is now taking psychiatric study under this same group.

There being no further business, the meeting adjourned to the buffet at 10:30 p.m.

EDWARD D. WILDMAN, M.D.

Reporter

Middlesex

Members and guests of the *Middlesex County Medical Society* and Bar Association enjoyed an excellent dinner at Oak Hills Manor, Metuchen, on January 18. Dr. Stanley Gadek and Dan Golden, Esq., were chairmen for the meeting which followed.

Judge William Smith, Chief Judge of U. S. District Court, presented a learned paper on "Neutral Medical Expert Evaluation in Personal Injury Cases." He believes the present system of defendant and plaintiff medical experts is being abused. He gave pro's and con's of a model plan which provides for a panel of neutral medical witnesses. The neutral medical witnesses could be called by any of three parties involved and all his reports would be given to all parties. The plan also advocates limitations on the hypothetical question in an attempt to cut down on its abuse.

THOMAS I. STEINBERG, M.D.

Reporter

Monmouth

The January meeting of the *Monmouth County Medical Society* was called to order at 9 p.m. by President Morton F. Trippe, at Monmouth Medical Center, Long Branch, on January 25.

An amendment to the constitution was passed changing the requirements for associate membership in the County Medical Society. These new requirements raise the period of associate membership from 1 to 2 years; emphasize the necessity to serve on the emergency medical service for the full term of the associateship and 70 per cent attendance at the regular meetings with attendance of less than 50 per cent being sufficient reason for refusal of active membership.

A discussion was held on "Independent Medical Practice versus Government Control." The panel was chaired by Dr. John F. Stockfisch and participating were Drs. C. Byron Blaisdell, Charles Zukaukas, Anthony Rifici and Daniel F. Featherston.

Dr. Zukaukas opened the discussion by stating that the reason for the poor public relations on the part of the American medical profession of today is the lack of a solid front, inadequate representation in the press, and an inadequate policing of our own ranks. He felt that the situation could be improved at the local level by establishing a full time executive director for the Monmouth County Medical Society. This executive would screen national and state legislation, administer the emergency medical care program, release information to the press, assemble statistics, and attend meetings of other lay groups concerned with medical care. He proposed that the salary for this man be approximately $10,000 a year with an additional $5,000 a year for office expenses, and that each member of the society be assessed $50 a year to pay for this expense.

Dr. Rifici felt that paid representation at the local level was not necessary and that the doctor should be his public relations man and speak out for his own ideals. He said that availability for emergency medical care was very important. Dr. Featherston stressed that a lay executive officer should not make decisions for physicians but should be under direction of the Executive Committee of the County Medical Society.

Dr. Blaisdell approved of the idea of a full time executive officer but noted that the man need not be a fact-finder since the American Medical Association and The Medical Society of New Jersey provide much information on statistics and legislation. He stressed the need for the physicians to be articulate and clear in presenting their views. He noted the need for working with labor organization and social welfare groups so that we can solve our problems of better medical care together. A considerable stimulus for the discussion was provoked by Dr. Lester A. Barnett, past president of the society, who wearing a disguise, presented an ultraradical socialist approach to medical care.

LEONARD S. DANZIG, M.D.

Reporter

Morris

In place of its regular January meeting, the *Morris County Medical Society* held a dinner-dance for members and wives. The time was January 21 and the place, the Knoll Club, Boonton. Music for dancing was supplied by Jerry Shard's Orchestra. Dress was black tie. There were 230 people in attendance in spite of the fact that the second heavy snowstorm of the winter had occurred the day before. Following a delicious dinner, members and wives enjoyed the dancing plus the opportunity to see old friends and make new acquaintances. Since such an affair was strictly an innovation for our Society, there was some prior concern about its success. However, owing to the satisfactory results of this venture, we can strongly recommend it to other county societies. Admission was by advance reservation, the latter by approximately two months to insure the financial arrangements.

Thanks are due to Dr. Seymour F. Kuvin, who acted as a committee of one to make all the arrangements for the dinner-dance. During the evening, announcement was made of the election of Dr. Julian F. Johnston, Chatham, to life membership along with presentation of a desk set in his honor.

CHARLES C. SCOTT, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on December 20, 1960 at 9:00 p.m. at the Medical Society Building. The meeting was called to order by Dr. F. Albert Graeter, president.

The following physicians were elected to membership: Active—Drs. John W. Bromley, John Campbell, Robert Cerfolio, William A. Dwyer, Jr., Herbert Staniszewski and Leonid Tzibrouk of Paterson; Mitchell Bernstein, Pompton Plains; Robert Dunkelman, Bloomingdale; Norman S. Hersh and Edwin J. Pear of Wayne; Philip J. Jasper and Jose D. Perez of Passaic; Peter M. Masley and N. Frank Riccioli of Clifton; and Richard W. Rado, Butler. Active by Transfer—Drs. Harold Stromeyer and Anthony T. Rose of Paterson. Associate to Active by Transfer—Dr. John T. Petrowski, Passaic. Courtesy—Dr. Harold H. Golz, New York. Associate—Drs. Basil G. Dibsie, Paterson and Saul L. Sanders, Butler.

Dr. Graeter read a communication from The Medical Society of New Jersey on the nominations of two non-medical scientists for election to honorary membership by reason of their outstanding contribution to the practice of medicine. The nominations were endorsed by the society members.

A form resolution on binding State Society members of the A.M.A. House of Delegates to vote for social security coverage at A.M.A. meetings was read by Dr. Graeter. After discussion a motion was made that the resolution be adopted for presenta-

tion to the 1961 House of Delegates at the annual state society meeting in May.

Dr. Jehl was called upon to speak to the members on the benefits derived by the Widows and Orphans insurance of the Medical Society and he urged all the members to join this group.

The meeting was then turned over to Dr. Edward Wolfson, Program Chairman. Dr. Wolfson called upon Dr. Jehl to introduce the first guest speaker of the evening, Mr. Joseph A. Britton of the American Mutual Liability Insurance Company. A very interesting discussion and question and answer period followed on the new professional liability insurance endorsed by our State Society. Dr. Wolfson then introduced Dr. Andrew C. Ruoff, III, who discussed the New Jersey Relative Value Index which was tabled by the House of Delegates at the last annual state meeting but will be reconsidered and voted upon at the annual meeting in 1961. A motion was made and approved that our Delegates be notified of the Passaic County Medical Society's acceptance of the R. V. I.

At the close of the program, a collation was served at a table attractively arranged in keeping with the Holiday Season, by the Hostess, Mrs. Irving T. Hayman.

IRVING CHRISMAN, M.D.

Reporter

Obituaries • • •

DR. LAURANCE P. RUNYON

A half-century of medical service came to an end on New Year's Day 1961 with the death of Laurance Phillips Runyon, one of Middlesex County's veteran practitioners. Born in New Brunswick in 1877, he received his M.D. degree from Columbia University in 1903. Dr. Runyon was one of the select group who organized the New Jersey Society of Surgeons. He was an active member of the Middlesex County Medical Society. At first a general practitioner, he devoted more of his time to surgery and had tours of duty as chief of surgery at both hospitals in New Brunswick. For more than two decades, he was chief of staff at Middlesex Hospital.

1961-62 MEMBERSHIP DIRECTORY

Is Your Listing Correct?

The 5th Edition of the biennial Membership Directory is scheduled for publication and distribution in the summer of 1961.

Make sure your listing is accurate and complete by checking your current listing and submitting any changes and/or additions PROMPTLY — in printed form—to the:

MEMBERSHIP DIRECTORY DEPARTMENT

THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton 5, N. J.

Book Reviews

Office Diagnosis. Paul Williamson, M.D. Philadelphia 1960. Saunders. Pp. 470. Well illustrated. ($12.50)

In some respects this is a unique volume. Dr. Williamson gives a practical discussion of diagnostic technics in the office. The book is written in breezy style, with wit as well as wisdom. The approach is conversational—"if you think the backache is of emotional origin, here are the questions you ask: 1. 2. 3." . . . "If you suspect a malignancy, first do this . . ." The author covers an astonishing kaleidoscope of symptoms—headache, obesity, coma, dyspnea, eyeball pain, constipation, dysmenorrhea, pain in the elbow, purpura, cramps and so on. All of the procedures spelled out here can be done in any reasonably well equipped general practitioner's office. This book will earn its shelf-space or (better) desk top space very quickly.

FELIX A. UCKO, M.D.

Law and Medicine. William J. Curran, LL.M.; S.M. Hyg. Boston 1960. Little Brown. Pp. 829. ($12.50)

Although intended for attorneys and law students, this unique volume will be of interest to any physician who goes to court, and to any who are interested in the overlapping problems of two proud professions. The book follows the traditional pattern of law study: inductive reasoning—that is, drawing general conclusions from specific cases. This is alien to the standard deductive reasoning used in medicine, where we start with principles and apply them to cases. Most physicians will find the inductive approach interesting and will see how readily you can learn principles this way.

The book covers the law of medical practice, concepts of the relatedness of trauma and disease, problems of medical proof, forensic psychiatry, legal standing of medical societies, and a glossary of medical terms. Professor Curran cites opinions of upper courts on leading cases, and gives extensive extracts from medical texts. We thus have a source book, a text, and a case book, all in one.

Professor Curran heads up the challenging Boston University Law-Medicine Research Institute, which is our country's most ambitious effort to integrate teaching in the two professions and build a bridge between them. This book is an admirable aid to this task. It is exciting reading, and its text will provoke thought in all who read it carefully. All in all, there is no other book quite like this.

HENRY A. DAVIDSON, M.D.

Career Finder. By Keith Van Allyn. Published 1960 by Personnel Research Bureau, box 38-311, Los Angeles 38, Calif. ($2.00) (Lower prices in quantities)

This is a large fold-over card containing questions on interests, activities, ambitions, training and experience in 45 different areas. It is arranged so that the subject, by checking yes or no, draws a vocational profile of himself which can then be keyed to a list of some 600 occupations. It will be useful to psychologists, and to psychiatrists who are willing to take time to appraise vocational aptitudes and interests. Some physicians might find it interesting to try it on themselves and their adolescent children.

ABRAHAM LEFF, M.D.

Rudolph Matas, A Biography of One of the Great Pioneers in Surgery. By Isidore Cohen, M.D., with Hermann B. Deutsch. New York, 1960. Doubleday & Co., Inc. Pp. 431 with 24 illustrations. ($5.95)

This well-documented biography of Dr. Rudolph Matas (1860-1957), prepared by his pupil and friend, Dr. Cohen, and Mr. Deutsch, a New Orleans author-editor, provides a readable account of the life and work of "one of the greatest surgeons the world has ever known . . . whose contributions were of value to the entire human race." Son of a Spanish physician-adventurer, Matas' long life spanned a period from the Civil War to the Atomic Age—an era productive of miracles in surgery as well as in other fields.

Born in 1860, near New Orleans, Matas took his M.D. degree at the University of Louisiana (later Tulane) at the age of 19. While still a medical student, in 1879, he had participated in an expedition to Cuba to study yellow fever, under the auspices of the short-lived National Health Service. Two years later Dr. Carlos Finlay reported studies which showed that the bite of the female *Culex* mosquito was responsible for the spread of the disease. These studies of Finlay were translated in 1882 by Matas, who was then editor of the *New Orleans Medical and Surgical Journal*. Matas was then called to Texas to help fight an epidemic of "yellow jack." One of his patients there was Dr. William C. Gorgas, later General Gorgas, conqueror of yellow fever in Cuba and Panama.

Another friendship established in his early professional days was with the writer Lafcadio Hearn—a New Orleans newspaper reporter who achieved fame through his travels and writings on Japan.

The branch of surgery for which Rudolph Matas is best known, vascular surgery, began with the first 'Matas operation' in 1888. He rejected the tra-

ditional ligation procedure for aneurysm recommended by John Hunter in the previous century. Instead he chose to suture the vessel wall from within, after obliterating the circulation above and below the aneurysm. At the age of 34, Matas was appointed professor of surgery at Tulane—a recognition of his skill and industry. An accidental surgical infection resulted in the loss of an eye. Undaunted by this handicap, he continued to serve for many more years. His love for writing shared a position with his love of operative surgery. He died on September 23, 1957.

Numerous honors came to him during his 97 years, including six honorary degrees and fellowships in professional organizations at home and abroad. He was president of the American College of Surgeons in 1925 and of the International Society of Surgery in 1937. He received the first American Medical Association Distinguished Service Medal in 1938. The library at Tulane Medical School was named in his honor. He sponsored the definitive history of medicine in Louisiana now nearing completion.

Matas' personal life and wide community interests are also carefully chronicled in this biography. A mixture of happiness and sorrow in his personal life tempered the kudos and glories of his professional career. A dedicated and original personality, Rudolph Matas' fine contributions to humanity and the medical profession will be long recalled by this interesting volume.

FRED B. ROGERS, M..D.

Analytic Methods of Protein Chemistry. Edited by P. Alexander and R. J. Block. New York 1960. Pergamon Press. Pp. 254. ($8.50)

Recently accelerating advances in biochemistry have largely paralleled ultraspecialization in research technics. This trend is most evident in the study of proteins and related substances. Renewed interest in viral and other nucleoproteins and in enzyme systems has led to continuous searching for better methods of investigation into structure, properties and characteristics of individual proteins. Until quite recently, protein research was hampered by lack of technics for isolation and purification of protein, which did not result in denaturation or irreversible changes in the material being investigated. New methods were being reported in foreign and American journals but these were not readily accessible to many investigators. This pioneer volume details the most important methods of separation, isolation, and purification of proteins, including many enzymes. The editors have chosen several noted workers, each well-versed in one or more advanced methods. Each section deals with a basic technic, and the most important modifications, selected from the extensive literature. Whenever practical, detailed descriptions of apparatus are given, including diagrams and photographs. Important applications and noteworthy results are mentioned. Many methods are given in step-by-step detail; other methods require elucidation. For this purpose, each section concludes with an extensive bibliography.

Many of our routine laboratory procedures were, until quite recently, merely research tools. One need only mention electrophoresis, chromatography, enzyme and hormone estimations. It is not too much to hope that certain of the technics described in this manual may find their place in the diagnostic laboratory. In the meantime, this volume is invaluable to anyone interested in research in any facet of protein chemistry. The complete set of three volumes will be an important asset to the basic library of any biochemical research laboratory.

PAUL STEINLAUF, M.D.

Diabetic Care in Pictures. Helen Rosenthal, B.S. and Joseph Rosenthal, M.D. Philadelphia 1960. Lippincott. Ed. 3. Pp. 225. ($4.50)

Visual aid is now, in many instances, a preferred way of teaching. Applied to a diabetic, this can save the physician, nurse or nutritionist many hours of explanation. *Diabetic Care in Pictures* is now in its third edition. It is a welcome addition to the facilities of anyone interested in diabetes.

In simple, direct language one gets acquainted first with the facts pertaining to the disease. The explanations are in understandable, everyday language. The scientific facts are presented correctly. Basic diets are outlined in detail, with emphasis on exchange values and their caloric values, (explained in household measures), and vitamin counts. Special diets for diabetics, such as a bland or sodium restricted, are dealt with separately. Short chapters are devoted to concentrated sweets and sweetening agents, dietetic foods and food fads.

Different forms of insulin and their actions are explained; the syringes, the procedure in injecting the solution, the sterilization of needles, are all presented in a simple direct way. There is clear elucidation of blood sugar examinations and urine analysis in the day-to-day control of the patient. Another chapter is devoted to the complications which may befall a diabetic patient. Emphasis is on hygiene and prevention by noticing the early signs when medical attention may prevent disaster.

Each chapter is profusely illustrated, studded with explanatory notes and charts. The material is dealt with very competently. The paper is of excellent quality. The print is large and easily readable. The book can be highly recommended to the patient and his family. This volume will help the physician in many ways in making the patient understand his condition and live with it intelligently.

OTTO BRANDMAN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MARCH, 1961 • VOL. XXXIV, No. 3

CONTROLLED TRIAL OF BCG VACCINATION IN A SCHOOL POPULATION

A study in the school systems of Muscogee County, Georgia, shows that BCG vaccination does not appear useful in the United States. The risk of developing tuberculosis was high for reactors to five Tuberculin Units of PPD, but very low for nonreactors.

Although some aspects of the role of BCG vaccination in tuberculosis control programs have been clarified by controlled field trials, divergent conclusions have been reached regarding its usefulness. This is well illustrated by two of the most recently reported trials, one involving a quarter of a million participants in Puerto Rico and the southeastern United States, and the other 56,700 subjects in Great Britain. Both reports agreed that the risk of developing tuberculosis was considerable among reactors to a low dose of tuberculin. But for the nonreactors, the British found a high risk of developing disease and substantial protection from vaccination, while the American trials led to the opposite conclusions, namely, that the risk for nonreactors was low and that the benefits conferred by vaccination were too slight to counterbalance its disadvantages.

The validity of the view that BCG vaccination should not be used in populations with low infection risks is supported by the results of a controlled trial of BCG vaccination among the school population of Muscogee County, Ga., begun in April, 1947. Observations during the ensuing 12 years show that the infection rate in the community has been low and diminishing, that reactors to a low dose of tuberculin ran the greatest risk of developing tuberculous disease, and that BCG vaccination had no demonstrable effect on the tuberculosis problem.

GEORGE W. COMSTOCK, M.D., and LAWRENCE W. SHAW. Public Health Reports, July, 1960.

All participants were tested with five Tuberculin Units of PPD (5 T.U.) and the nonreactors were tested with 100 T.U. Reactors are defined as persons with 5 millimeters or more of induration to the specified dose of PPD.

STUDY POPULATION

The study population consisted of 11,262 children with an average age of 11 years. Of the total, 1,492, or 13 per cent, reacted to 5 T.U. and another 3,768 (one third of the study population) were classified as reactors to 100 T.U. When certain "irregulars" were eliminated, there were 4,839 nonreactors to both doses who were divided into two roughly equal groups, one to be vaccinated and the other to serve as unvaccinated controls. The vaccine, supplied by Dr. S. R. Rosenthal of the Research Foundation, Chicago, was administered by multiple tangential acupuncture on the third or fourth day after preparation.

Six months later, 70 per cent of the vaccinated students were retested with 5 T.U. and 100 T.U. of PPD. Ninety-three per cent were reactors to one of the doses. Nonreactors to the higher dose were revaccinated.

In the 12-year period from April 1, 1947 through March 31, 1959, 35 cases of definite tuberculosis were discovered among the total study population, an average annual rate of 26 per 100,000. The rate for 5 T.U. reactors was tremendously higher than for nonreactors, 134 for reactors and only 9 for nonreactors. No

significant differences were noted among nonreactors to 5 T.U. according to their sensitivity to 100 T.U. The rates among controls and vaccinees were the lowest observed and were essentially the same. Although too few cases were observed among controls and vaccinees to attempt any assessment of the efficacy of vaccination among nonreactors, it is obvious that vaccination was not completely effective.

REACTORS TO FIVE T.U. AT RISK

The findings of this study support the conclusions of subsequent controlled trials of BCG vaccination in Puerto Rico, Georgia, and Alabama. The most striking finding of these trials, and of the present trial as well, was that persons who were reactors to 5 T.U. of PPD had the greatest risk of developing tuberculosis. A corollary to this finding is that nonreactors to 5 T.U. had such a low risk of developing tuberculosis that there is serious question about the need for vaccination of nonreactors in this country. So low is this risk in the present study that only 11 cases of tuberculosis were found among nearly 10,000 nonreactors during a period of 12 years.

The conditions of the present trial are closer to the BCG trial conducted by the British Medical Research Council than any controlled trials previously reported.

Among reactors to the 5 T.U. dose in Muscogee County, 16 new cases are known to have developed in the first eight years, where 12 would have been expected at the British incidence rate. This is close agreement, and suggests that the risk for British and Muscogee low-dose reactors is generally similar.

On the other hand, where 2 cases had been observed in the first eight years among unvaccinated controls, 34 would have been expected had the British rates applied. This is a striking difference.

Comparison of the results of these two trials suggests that the risk of infection must have been many times higher in Great Britain than in the United States. This has a direct bearing on the need for vaccination in the two areas, since it seems obvious that the need for vaccination varies directly with the likelihood of becoming infected.

TUBERCULIN TESTING PROGRAMS

One finding strongly suggests that the currently popular tuberculin testing programs among school populations must be carefully done to define as sharply as possibly the small group at greatest risk, namely those with 10 mm. or more of induration to 5 T.U. It appears that this small group should not only be x-rayed promptly but also should be kept under surveillance with annual chest x-rays for at least five years.

In areas where the infection rate is low, it seems that repeated tuberculin testing of entire school populations on an annual basis may well be inefficient. In such areas, it would be more reasonable to test the school population on entrance to school and again during adolescence.

It is now recognized that tuberculosis among the currently uninfected population in the United States is not of critical importance, but rather that the already infected population is the important seedbed of future disease. It is thus essential to discover some effective means of preventing the development of disease among apparently healthy reactors, thereby sterilizing the present seedbed of disease before another crop of tuberculosis cases can be germinated.

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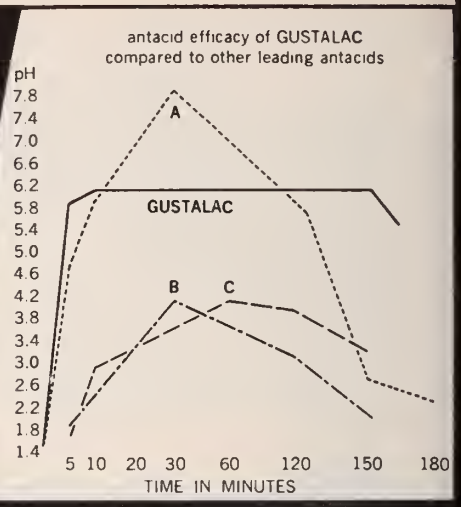
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1. Kirstner, J. B.: J.A.M.A. 166:1727, 1958.

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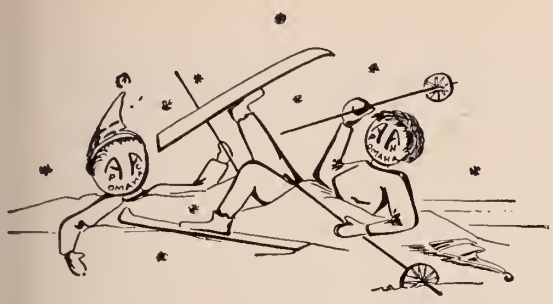
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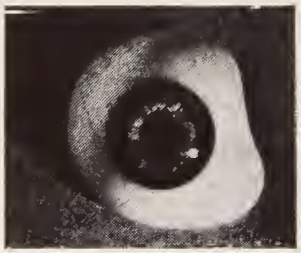
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References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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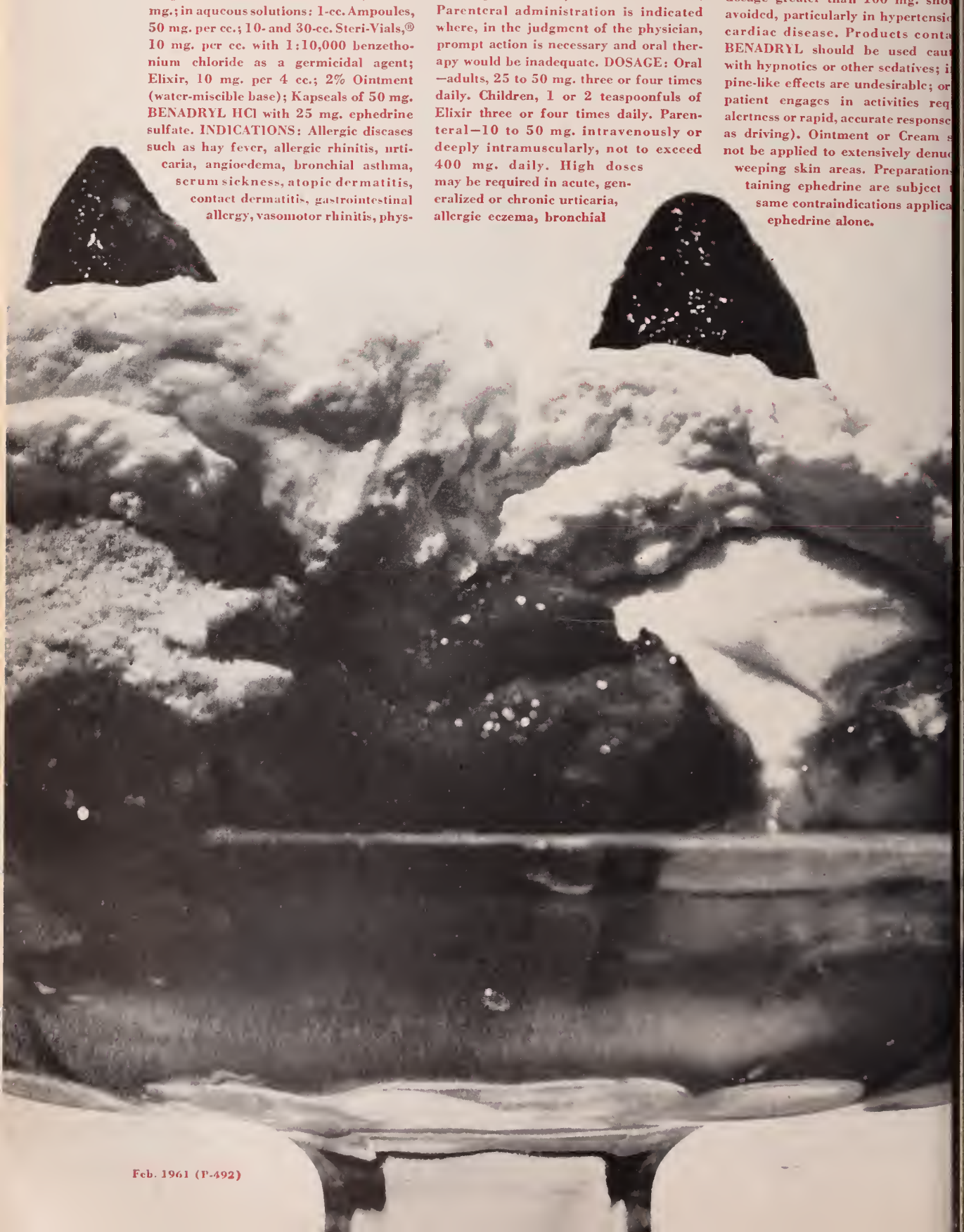
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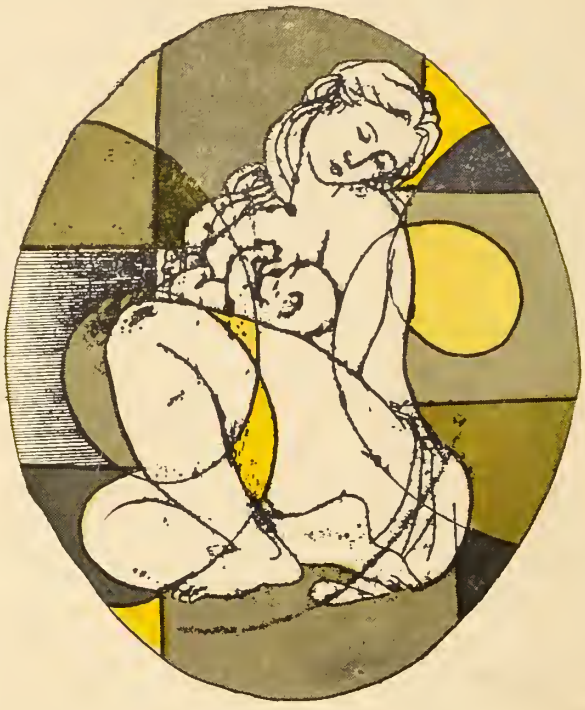
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OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 58, NO. 4 APRIL, 1961 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

THE N.Y. ACADEMY OF MEDICINE
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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.
Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.
Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.
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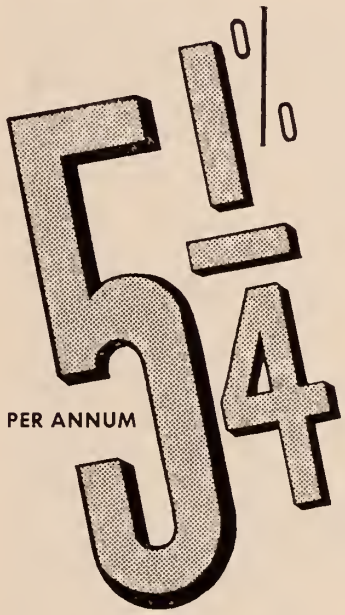
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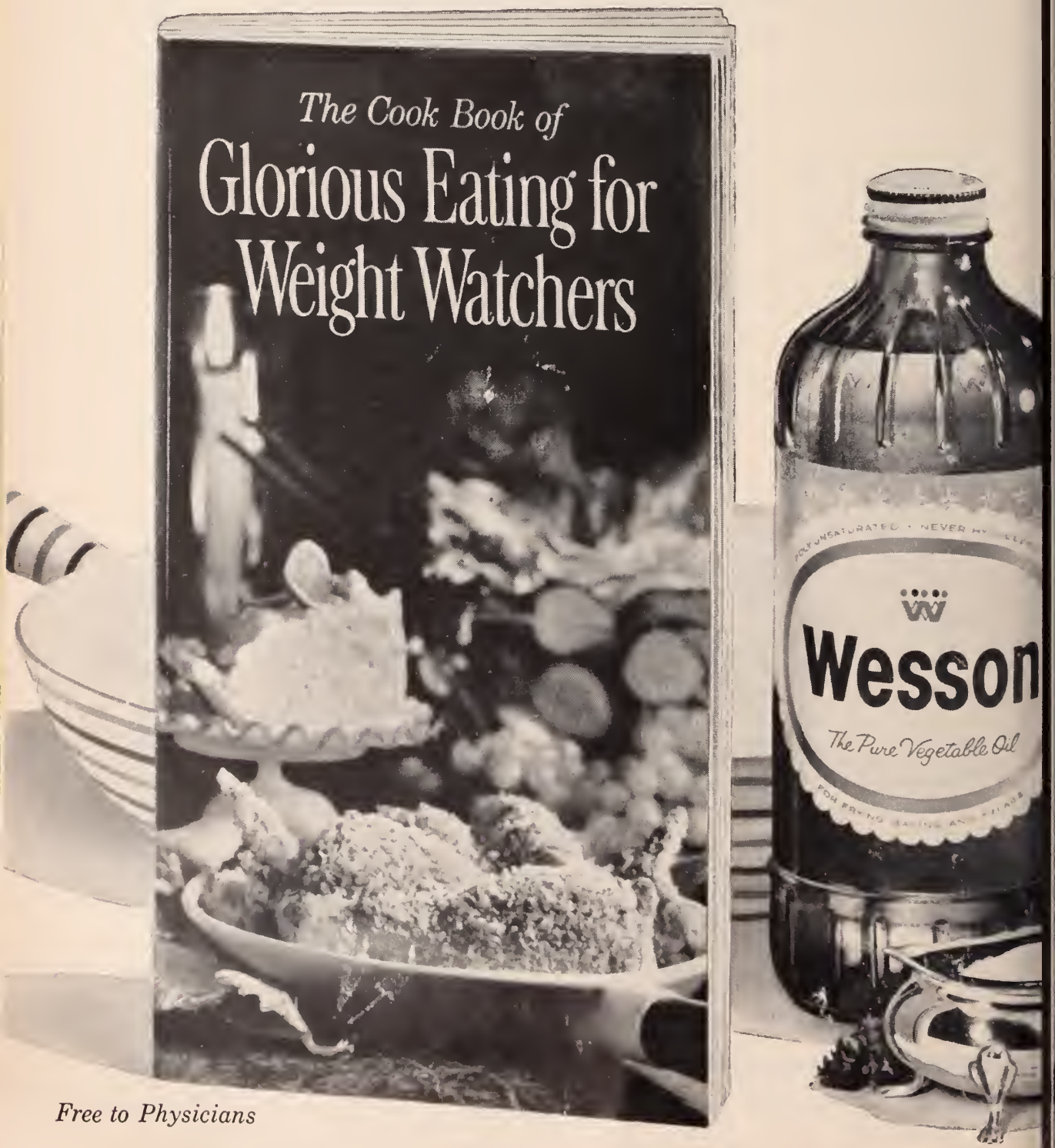
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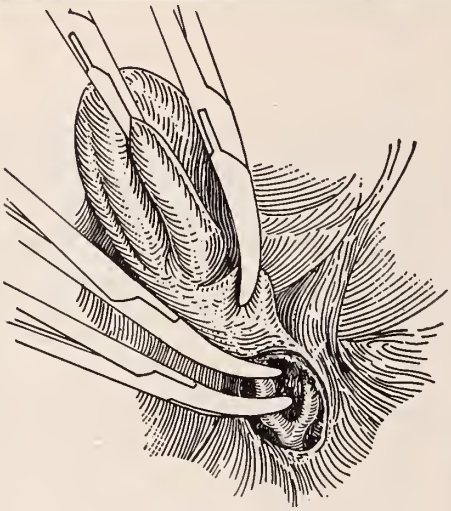
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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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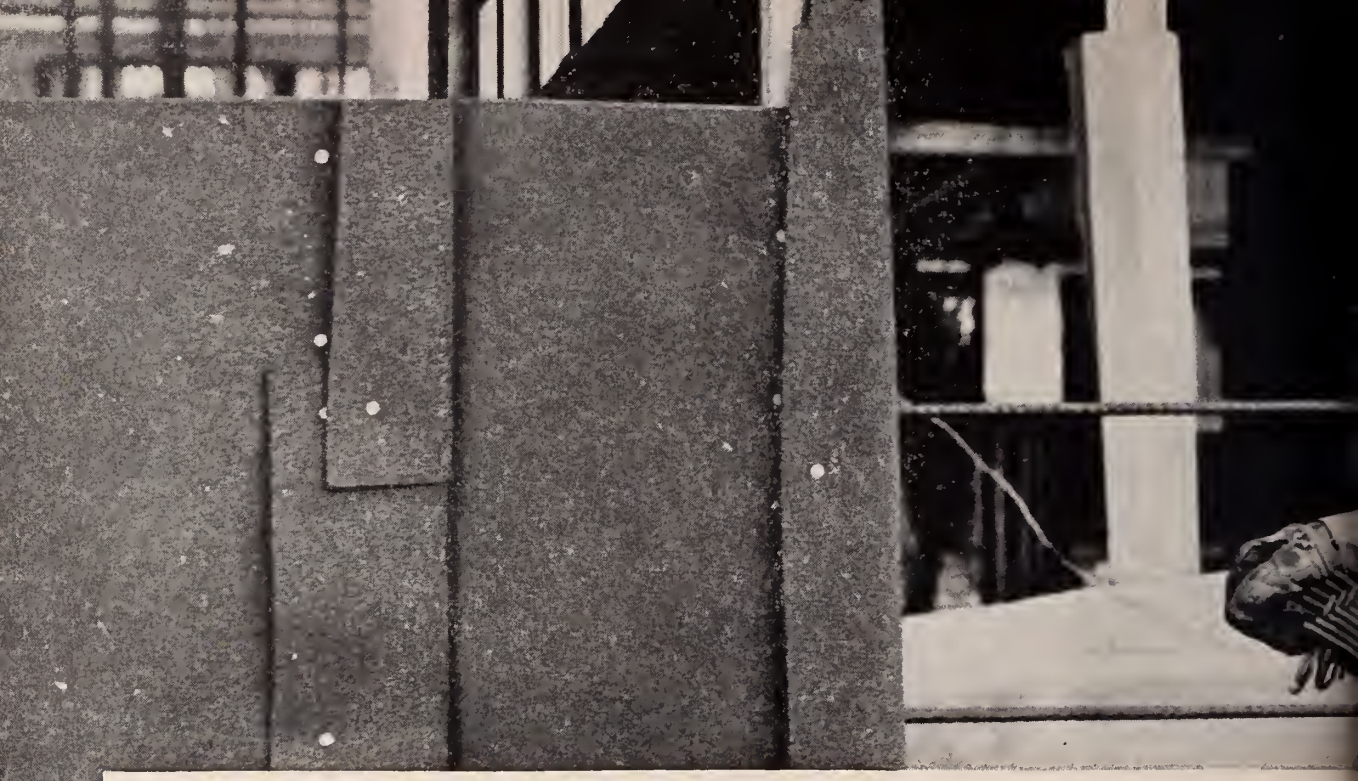
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Case history courtesy of Joel Goldman, M.D., Johnstown, Pa.
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A. Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:72 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958

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1. Levy, S.: J.A.M.A. 153:1260, 1953.

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Literature available to physicians on request.

REFERENCES: 1. Carpenter, E. B.: Southern M.J. 51:627, 1958. 2. Forsyth, H. F., J.A.M.A. 167:163, 1958. 3. Hudgins, A. P.: Clin. Med. 6:2321, 1959. 4. Grisolia, A., and Thomson, J. E. M.: Clin. Orthopaedics 13:299, 1959. 5. Lewis, W. B.: California Med. 90:26, 1959. 6. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 7. Park, H. W.: J.A.M.A. 167:168, 1958. 8. Plumb, C. S.: Journal-Lancet 78:531, 1958. 9. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 10. Schaubel, H. J.: Orthopedics 1:274, 1959.

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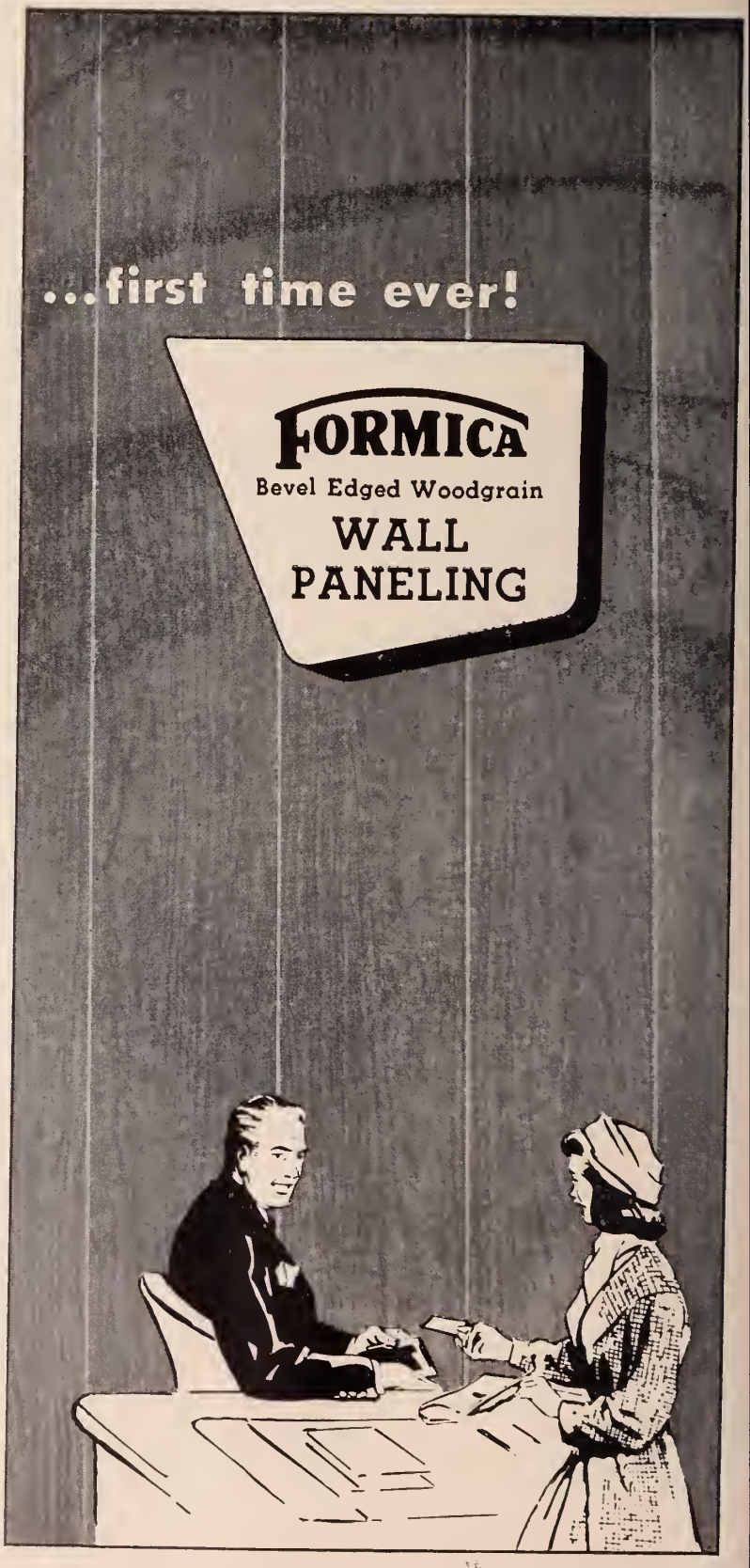
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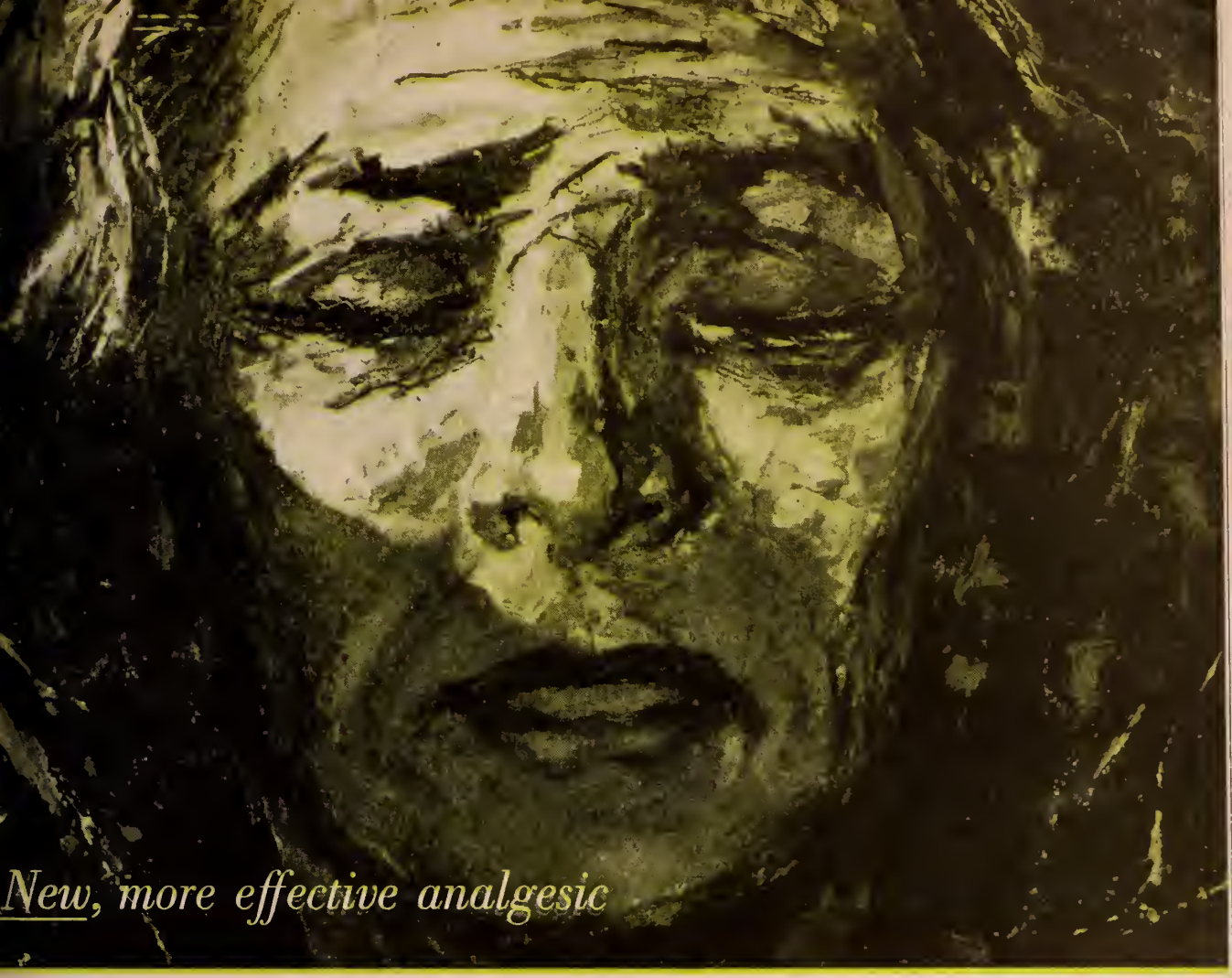
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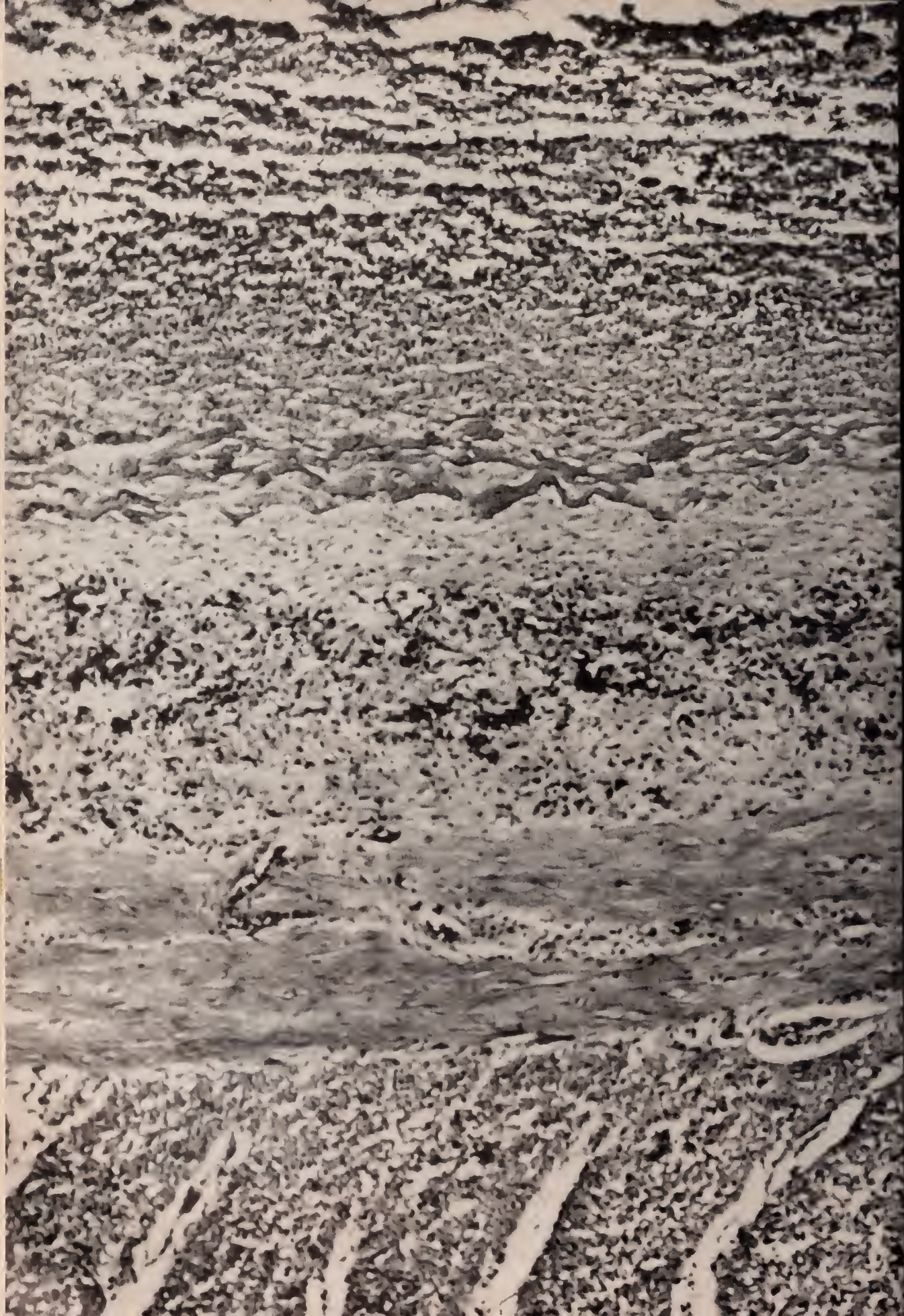
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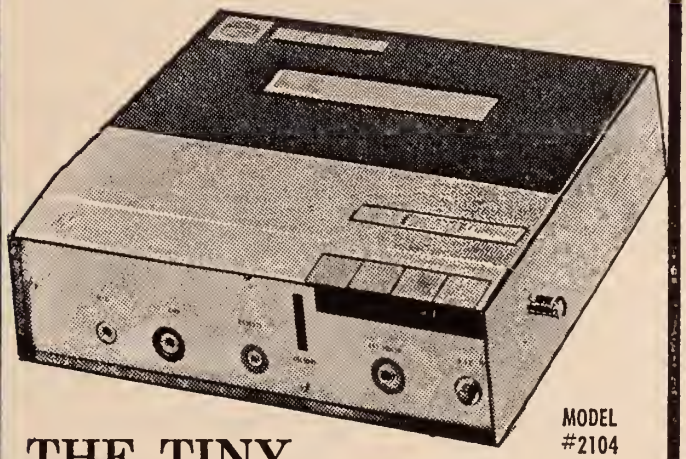
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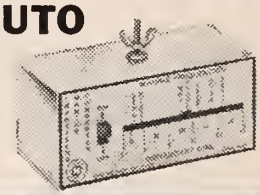
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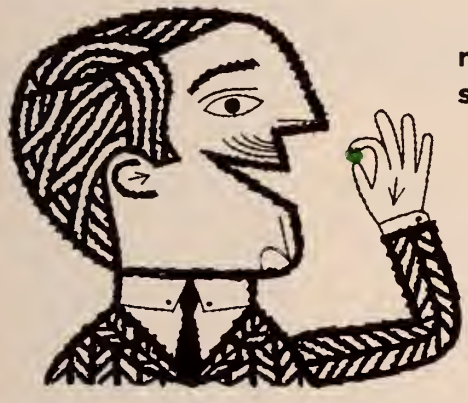
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Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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STUDY 1 *Spoor, H. J.: N. Y. State J.M. 58:3292, 1958.*

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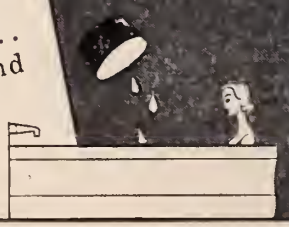
STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

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- senile pruritus
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- neurodermatitis
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1. Bagnoll, A. W.: Antimolorlol compounds in rheumotoid disease, Conad. M.A.J. 82:1167, June 4, 1960.

2. Cornbleet, Theodore: Discoid lupus erythemotosus treoted with Ploquenil, A.M.A. Arch. Dermot. 73:572, June, 1956.

*Plonolor, trademork

Ploquenil (brond of hydroxychloroquine), trademork reg. U.S. Pat. Off.

STEREO SYSTEM FOR A MILLIONAIRE: 4 SELECTIONS

Gentlemen's Quarterly magazine asked James Lyons, editor of *The American Record Guide* (the oldest record review magazine in the United States), to poll hi-fi authorities on which audio components they would choose for the best possible stereo system, without any regard for price.

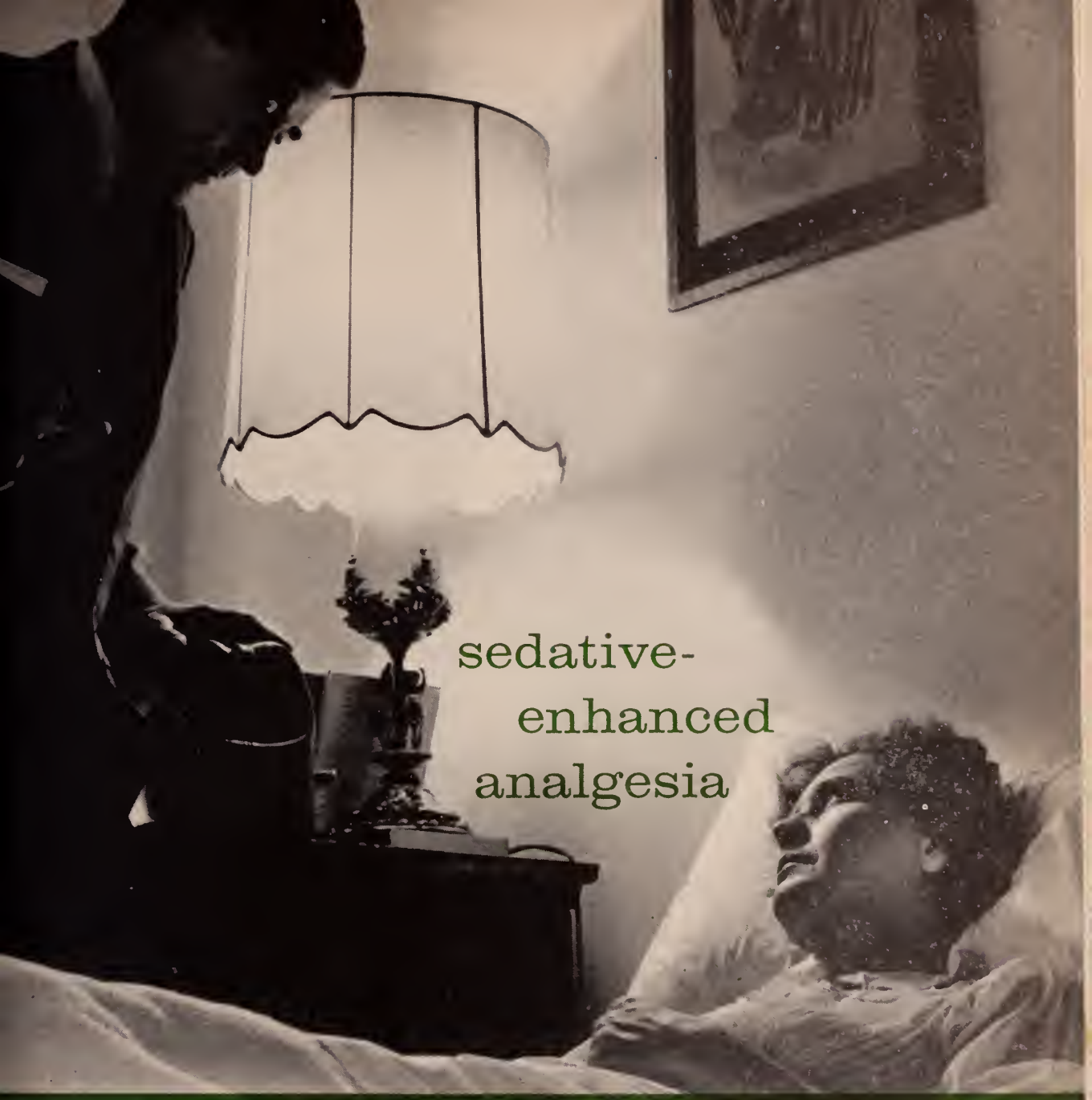
Three writers in the audio field and one audio consultant made up independent lists. The ideal systems they projected in the April, 1960 issue of *Gentlemen's Quarterly* are suitable for discriminating millionaires—one of the systems, using a professional tape machine, would cost about $4000.

ACOUSTIC RESEARCH AR-3 loudspeakers are included in three of the lists,* and these are moderate in price. (There are many speaker systems that currently sell for more than three times the AR-3's $216.) AR speakers were chosen entirely on account of their musically natural quality.

Literature on Acoustic Research speaker systems is available for the asking.

In two cases alternates are also listed. For the complete component lists see the April, 1960* ***Gentlemen's Quarterly**, or write us.*

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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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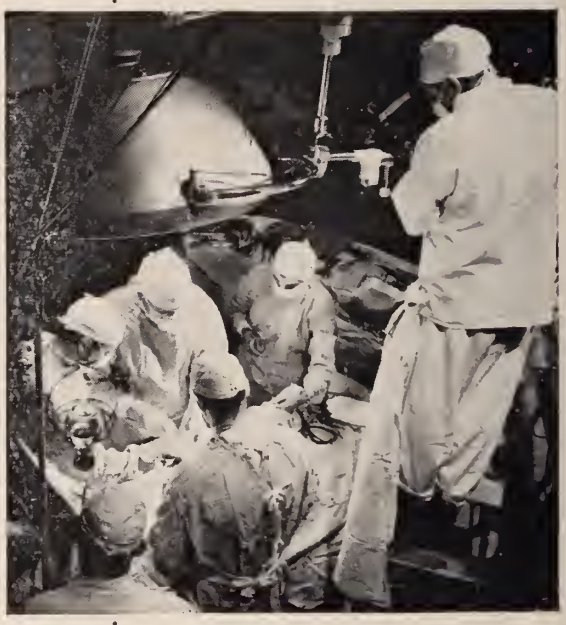
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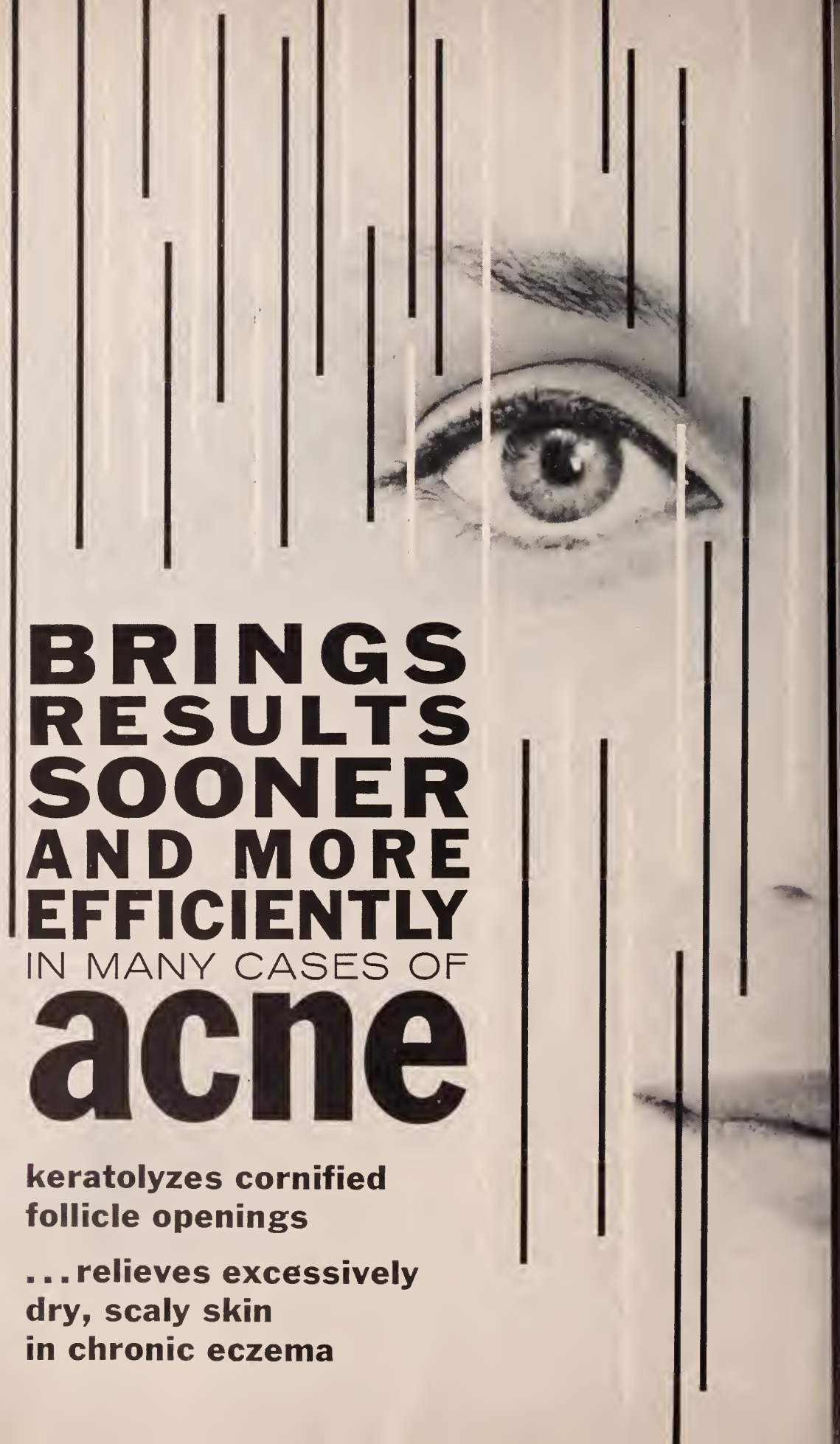
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Nutrament also is useful for obstetric patients who often require sound, easily tolerated, and convenient nutritional supplementation during pregnancy and lactation;[2] and for geriatric and other patients who cannot or will not maintain proper nutrition because of poor dentition,[3,4] faulty eating habits,[1,3] or lack of interest in eating.[3,5]

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Nutrament liquid, sipped directly from a glass or through a straw, may be used to provide good nutrition in patients who are unable to chew solid foods or in whom solids are contraindicated.

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Even though prescribed, adequate diets may not be consumed because of the difficulty of providing personalized nutritional supplementation and encouragement of feeding.[6] Nutrament is easily adjusted to the individual patient's needs; provides excellent nutritional support; requires no special preparation.

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Vitamin A (U.S.P. Units)	1250	30
Vitamin D (U.S.P. Units)	125	30
Vitamin C, mg.	50	166
Thiamine, mg.	0.5	50
Riboflavin, mg.	0.6	50
Niacinamide, mg.	5.0	50
Calcium, Gm.	0.5	67
Phosphorus, Gm.	0.4	53
Iron, mg.	4	40
Iodine, mcg.	60	60
Vitamin E (Int. Units)	2.5	
Pyridoxine, mg.	0.4	
Vitamin B_{12}, mcg.	0.5	
Calcium pantothenate, mg.	2.0	
Sodium, Gm.	0.2	
Potassium, Gm.	0.9	
Copper, mg.	0.5	
Manganese, mg.	1.0	
Fiber, Gm.	0.55	

ingredients

Whole milk, skim milk, sugar, soy flour, Dextri-Maltose,® (maltose and dextrins derived from enzymic action of choice barley malt on selected corn flour) starch, chondrus extract, sodium alginate, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, niacinamide, ferrous sulfate, sodium iodide, d-alpha-tocopheryl acetate, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, salt, cupric carbonate, manganese sulfate, cocoa and/or vanilla flavor.

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references

(1) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (2) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (3) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960. (4) Shaw, J. H., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, pp. 558-601. (5) Campbell, D. G.: *ibid*, pp. 888-910. (6) Abbott, W., in Allison, J. B.: Ann. New York Acad. Sc. *69*:1018-1022 (Jan. 10) 1958.

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by Mortimer L. Schultz, Chairman of Board, Office Buildings of America, Inc., Newark, New Jersey

Mr. Schultz has talked on real estate syndication before hundreds of college, medical, executive and real estate groups throughout the Northeast. The questions presented below are representative of those most often asked by doctors' investment groups and from inquiries received from doctors.

Q What is a Real Estate Syndicate?

A A group of investors who will purchase one particular property together. This property being of a size beyond the means and desire of any one alone.

Q What are current yields and how are they paid?

A Yields currently range from 7 to 14% and because of the nature of real estate syndicates, cash distributions are paid monthly.

Q How can syndicates benefit a doctor?

A Subject to the risks inherent in real estate, participation in syndicates can convert ordinary income into long term capital gain type of income and lessen the investors' tax burden.

Q Show an example of how ordinary income converts to long term capital gains.

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Q What is the liability of an investing partner?

A A limited partner risks his investment only, and this investment may range from $2,500 up depending on the cost of a unit of participation.

Q Are partnership interests marketable?

A At a price, a willing seller can always find a willing buyer, thus partnership interests are marketable. Many investment firms, such as First Jersey Securities Corporation, have created a secondary market for the resale of syndication units.

Q Who is the typical syndicate investor and how much has been invested in syndicates to date?

A A survey recently taken shows the typical investor to be (a) in his forties or fifties, (b) an executive or professional man with an income of $10,000 to $50,000 and (c) with $5,000 to $35,000 invested in two or more syndicates. Syndicate investments throughout the country are currently at a rate of three billion dollars annually.

Q What is Office Buildings of America, Inc.?

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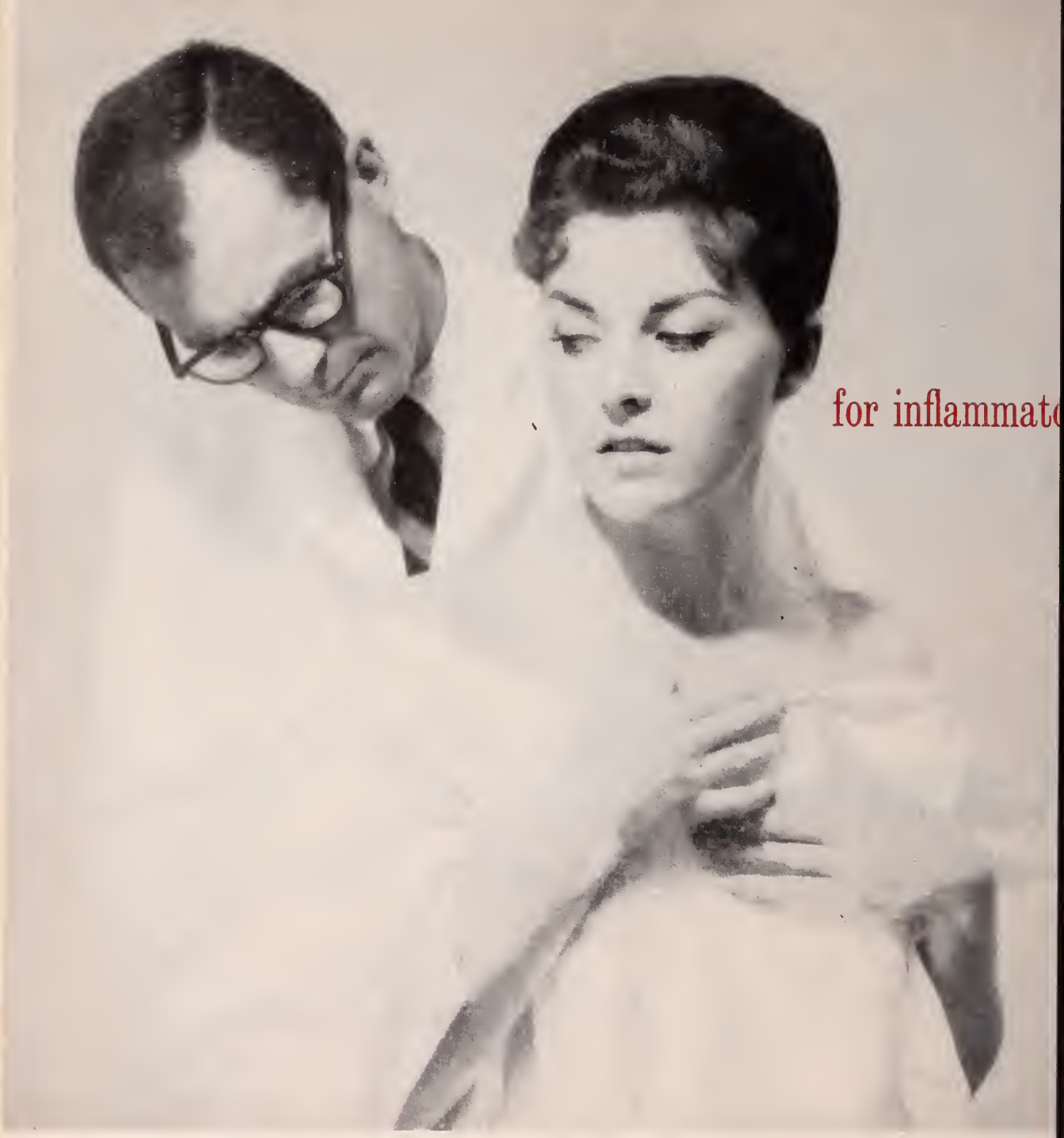
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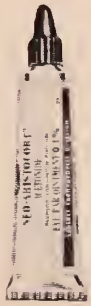
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This diagram represents the lateral aspect of the upper respiratory tract. The mouth, anterior to the glossopalatine arch, has been omitted. Skeletal landmarks are shown in color-coded serial sections.



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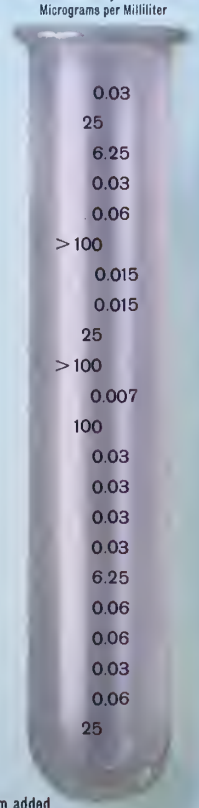
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Corynebacterium xerosis	0.03
*Diplococcus pneumoniae	0.06
Escherichia coli ATCC 8739	>100
Gaffkya tetragena	0.015
Micrococcus flavus	0.015
Salmonella paratyphi A	25
Salmonella typhosa	>100
Sarcina lutea ATCC 10054	0.007
Shigella sonnei	100
Staphylococcus aureus 209P	0.03
Staphylococcus aureus var. Smith	0.03
Streptococcus agalactiae ATCC 1077	0.03
Streptococcus dysgalactiae ATCC 9926	0.03
Streptococcus faecalis PCI 1305	6.25
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Streptococcus pyogenes 2320	0.03
Streptococcus pyogenes 23586	0.06
Vibrio comma	25

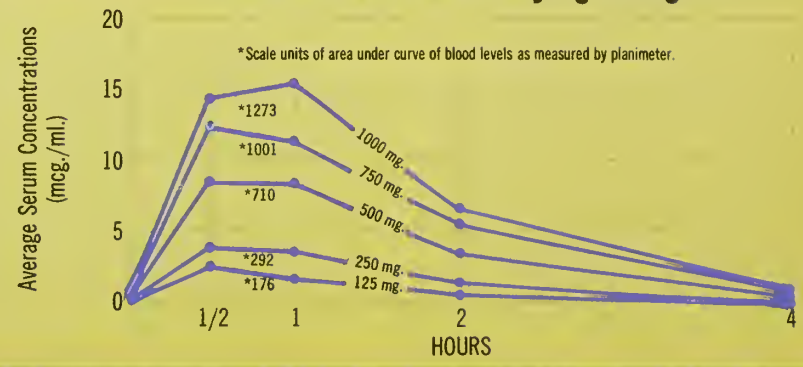


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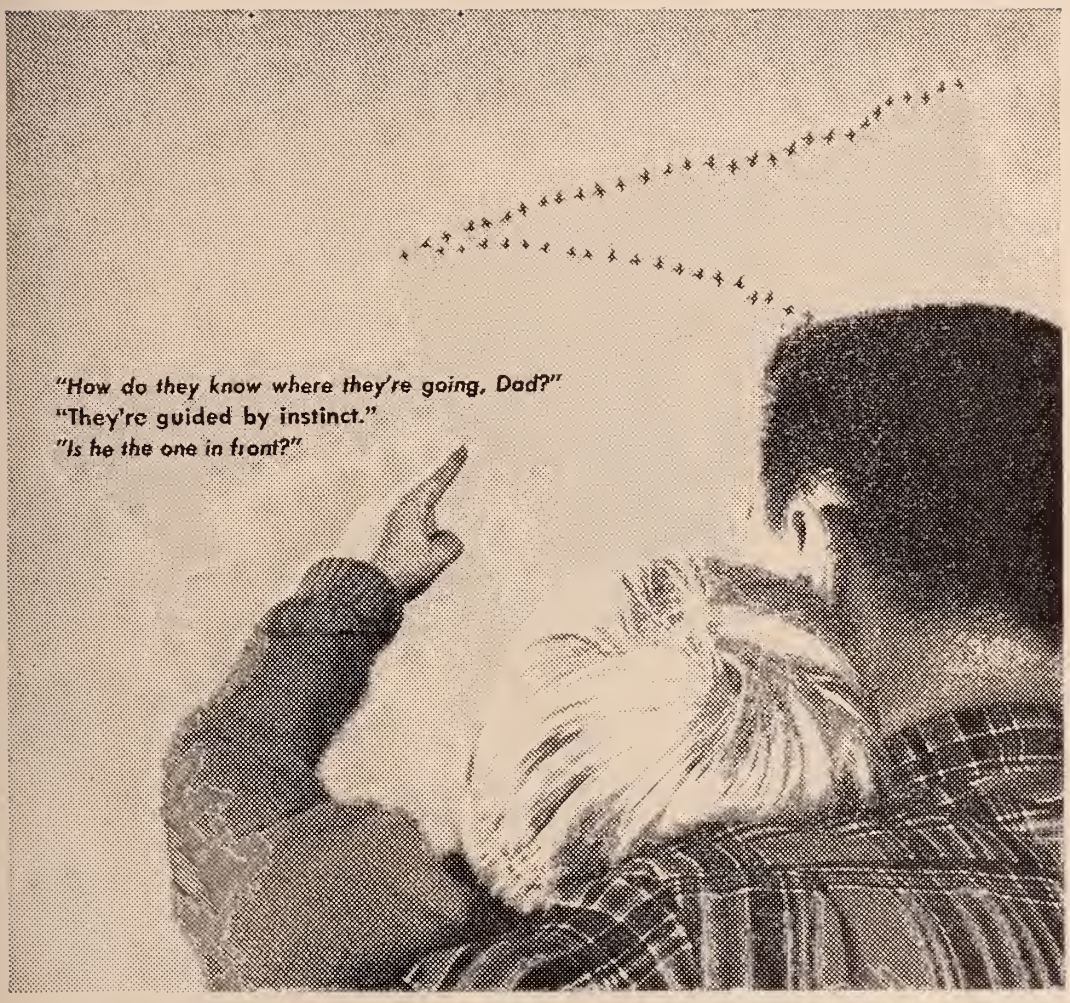
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(Continued from preceding page)

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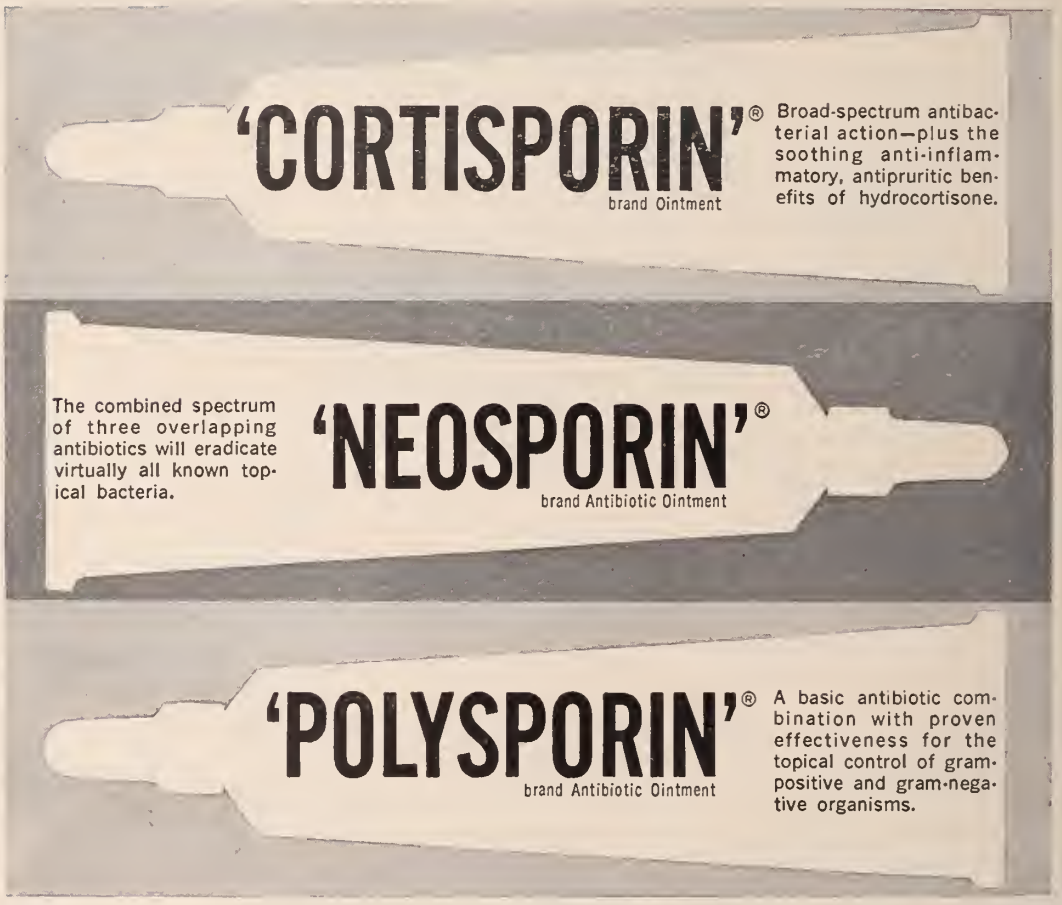
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THE JOURNAL
OF
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Editorials • • •

The Perils of Perfection

Some physicians think that they are in the business of trying to make people normal, and to make organs function perfectly. We take it for granted that it is desirable to be free of symptoms, to achieve perfection in organic function, and to squeeze into the vague but desirable mould of "the normal."

In theory, we know, there is no way of achieving the ideal. But we try. We aim at ideal weights, and ideal blood counts, and ideal x-ray findings. We assume it would be cause for congratulation if we could get the harassed, worried, hypertensive executive to take it easy. But we forget that if he succeeded in taking it easy, his business might collapse. It needs a compulsive, self-driving, potentially hypertensive boss to keep it going in high gear. If the doctor succeeded in relaxing the executive to the point of hypotension, profits would fall, stock-holders would swear, and laid-off employees would then develop high blood pressure.

Peptic ulcer is said to be related to repressed hostility acting on a hyperacid, hypermotile stomach. If we achieve perfect digestion, the victim will either exhibit his hostility (instead of repressing it), or give up the fight entirely and stop being hostile. If he does that, he may lose the passion which kept him going. If he exhibited the hostility instead of repressing it, he would exchange an unpleasant but benign ulcer for a dangerous, possibly fatal coronary.

Let's face it: neither the human body nor the human mind, nor—for that matter, the human soul—is perfectible. Crises keep us

Published Monthly Since 1904
Under the direction of the Committee on Publication
Fred B. Rogers, M.D., *Chairman*

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Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of The Journal every month

Whole Number of Issues 680

Vol. 58, No. 4 April, 1961

Subscriptions, $3.00 per year
Single Copies, 30 Cents

toned up. Without them, we would lose muscle tone and emotional drive. But with crises we have other problems. People are entitled to emotional storms—even to occasional "breakdowns" of such severity as to require hospitalization. The neatly patterned carpet or blanket, has a chaotic pattern on the underside. It is possible to have a body with no tension and a mind with no worry—a dead body, of course. The most important tasks of our time cannot be filled by men who are free of anxiety. Anxiety is the motor that drives us. A machine can function free of anxiety—but not a human being. And you can't enjoy being human, if you have to brood about your score. If you can't enjoy your own abilities, because of a hopeless pursuit of perfection, you will lose on both scores. You won't make enjoyable use of your limited potential —and you won't achieve perfection either.

The human being has all kinds of foibles—physical, spiritual and emotional. But since he is stuck with those limitations, he should learn to enjoy them. Perhaps this is our mission: to show how our patients can live with their modest human skills rather than to send them off on the wild goose chase after the mythical norm.

The Why and How

The flood of medical literature threatens to engulf us all. A natural reaction has been to demand that articles, demonstrations and lectures concentrate on the "how to do it" aspect of medical practice. The highest praise is to say that a presentation is practical—down to earth—over the counter. Many of us yawn when we see space devoted to historical background or to "theoretical" or basic underpinnings. We want to know what drug to give, by what route and in what dose. But we won't take time to understand the pharmacology and pharmacodynamics of its effectiveness. We demand the "how" and are impatient with the "why."

For a long time, the practitioner's traditional technic of keeping up, has been the "refresher"—a course, a lecture, an article which lists the latest drugs and procedures. But new medical learning must be something more than the adding of new gadgets, new drugs or new procedures. It requires a change in the *understanding* of body physiology, for instance. A doctor out of medical school more than 25 years does not understand current methods of testing liver function unless he has specifically been taught about them—or taught himself. No matter how good his recollection of liver function testing prior to 1935, he still will not have a mastery of 1961 methods in this area unless he has been re-educated—not just refreshed. But this is precisely the kind of graduate education we balk at. We want to know what tests to order, for example —and how to interpret them "clinically." We don't have time (we say) to learn the basic rationale of these tests. Indeed, we brand this rationale with our most terrible adjective: "theoretical."

But, as has been said before,* there is nothing so practical as a sound theory.

*We have been unable to trace the source of this aphorism about theory. Our favorite book of quotations has no entries between theologian and theosophy—neither of which was any help here. Does any reader know who first said this?

ALBERT G. HULETT, M.D.

Orange

Modern Drugs: How Shall We Prescribe Them?

Dr. Hulett puts his finger on a sore point in modern practice and offers a sensible suggestion. Why can't the authorities give us simple generic names?

THOSE of us who have been in practice for many years have watched medical science, and especially the matter of drug-therapy, grow from relatively simple and limited remedies to the tremendous resources now available in the form of newly-developed preparations the like of which neither our forefathers, nor we ourselves in student days, ever anticipated. To have such medicinals awaiting our prescription is splendid for our patients. But what of the effect upon the doctors who must write prescriptions for them?

Repeatedly, in pronouncements by the A.M.A. and by our State Medical Societies, as in repetitious editorial articles,* we are admonished *not* to write prescriptions which call for drugs by their trade-marked, or brand names, but rather *always* to write the generic, pharmacal, or chemical name. The justification advanced for this is that trade-names restrict the druggist to the product of the one manufacturer who owns the trade-name. Often, the pharmaceutically identical drug is available from several manufacturers. In many cases the non-trade-marked item will be less costly for the patients. This practice also spares the druggist the need to maintain unnecessarily large stocks of medicinals so that he can fill prescriptions by brand-names. This is a tenable thesis—to a certain point—but only that far. At once, let me flatly deny that I wish to promote the profits of any pharmaceutical firm. In truth, I am anxious only for the welfare of my patients, and for my own clear conscience and future sanity, when I declare that the problem of prescription-writing for today and tomorrow has certainly *not* been solved by these restrictive admonitions.

MOST of our newer medicinal products are of complex structure and of even more complex terminology by chemical designation, and but little less so by generic nomenclature. Again, for many of them, there simply is no generic name in evidence; so we must use the chemical title, if brand-names are taboo. To make the situation even worse, the generic names assigned to these drugs, are oft-times, so very similar in sound (and even in spelling) that I must refer to the *Physicians Desk Reference*, the *Modern Drug Encyclopedia*, or some text-book, to make certain that I do not order something for my patients which they are not meant to have—or even something which might be distinctly harmful. I wonder how many other doctors have experi-

*Your editor pleads *non vult*—H.A.D.

enced similar anxieties? Also, how many have wanted to write for a certain drug but, in desperation, have compromised for another simply because they couldn't spell the one they really desired, or couldn't be certain that they had rightly remembered its generic name?

As an illustration of what I intend, consider the prescription I wrote, some months ago just after reading one of those editorials. I wanted to provide a patient and his wife, who were embarking upon an ocean cruise, with some Dramamine® tablets to combat seasickness. I consulted the "authorities" only to discover that there is no generic name for Dramamine®. So, . . . I bravely wrote a prescription for thirty tablets of "Beta-dimethylaminoethyl benzohydril-ether-beta-chlorotheophyllinate-dimenhydrate." the precise chemical name. An hour later the pharmacist phoned: "What in blazes is the drug you ordered for Mr. Short?" Such experiences are not at all unusual when we conform to the taboo upon brand-names.

Even the valiant efforts devoted to the selection of generic names for our modern medicinals present problems fraught with hazards and embarrassments for doctors and patients. Consider just four products: nialamide, niacinamide, Proniazid® and isoniazid. How easily the busy doctor can jot down one in his prescription, or even choose the wrong one! And cannot the pharmacist as readily make mistakes in filling such prescriptions? Obviously the "generic pickers," being human, have chosen unwisely at times, and seem not to have found "nick-names" for all of these newer drugs. Meanwhile, just how shall doctors prescribe if they are to avoid brand-names and if they find that memorizing—or even copying down—of half-mile-long chemical names are too much for them? Suppose that a doctor wants his psychoneurotic patient to have Nardil® but dares not order it by that brand name. Shall he write "Phenelzine dihydrogen phosphate"—and then pray to God that he has stated the order properly and that the druggist will recognize what is wanted? Or consider the hazard confronting the doctor and his patient for whom one of the newer diuretics is intended to be prescribed. He dare not write for Ecolid®, Esidrix,® or Diuril®. So far as I can discover there are no generic names for these, and others in that class. So shall he prescribe "chlorisondamine chloride," or "hydrochlorothiazide," or "chlorothiazide?" And if he does, how certain can he feel that he has ordered the drug he desired—unless he "consults the book" in front of the patient before he writes?

ANOTHER facet of this problem of nomenclature of modern drugs concerns our current medical literature. In many medical journals* —(by editorial edict)—none but the generic or chemical names of medicinals may appear. In prior times a doctor might relax of an evening in his easy chair and enjoy perusing medical journals to learn about new methods, new diagnostic procedures and new remedies. Today he cannot "relax and enjoy" such educational endeavors, for he must have at hand a *Modern Drug Encyclopedia,* or a *Physicians Desk Reference,* to which he must refer repeatedly to know just what drugs the authors are discussing. The result is that, too often, the busy doctor lays aside his medical journals to gather dust, awaiting the fond day (which never dawns) when he might have the time and energy to "translate" these articles into comprehensible terminology. And, may I ask, how many readers have done just that?

Illustrations of the dilemma could be extended almost to infinity but it is not necessary to do this to establish the truth of the matter. If the trend continues, the point may be reached when young men will be afraid to become doctors and those already in practice will—in self-preservation if not in panic—either become "therapeutic nihilists," or embrace some drugless "ism" to escape the dilemma. And may we not anticipate that a few who are of braver mien will embark upon some nonmedical career, or even just swallow enough cyanide to obtain escape? But—and this is truly heartening—such trend does not

have to continue. Even the predicaments now confronting us can be greatly ameliorated, if only something is done by the "proper authorities" to provide simple and non-confusing names for the new drugs which can then receive official approval from "the powers that be." I do not deem this to be an impossible proposal, nor do I believe it to be an unreasonable one.

Nobody would advocate that we revert to the form of medical practice of an half-century ago; nor would we want to return to the old-time medicinals of far lesser remedial potential than present day drugs possess. I merely present a plea for sufficient simplification, rationality and common-sense, as may promise the attainment of some degree of order out of the current—and steadily increasing—chaos which now engulfs the medical profession in its prescriptive endeavors and its necessitous attempts to become adequately informed as to new discoveries in therapeutics. As Patrick Henry once exclaimed, "If this be treason, make the most of it."

184 Tremont Avenue

The Need for a "Sports Medicine"

J. D. Troup in the Sept. 24 (1960) *Lancet* (2:699) suggests that we need a new specialty: sports medicine. Investigations, he believes, should be made into the physiology, psychology and other medical aspects of sports to develop better performance and to provide insight into some illnesses seen outside the world of sport.

Doctors know little of mechanical injuries such as sprains and are unable to advise sportsmen how to avoid such disabling injuries. Injuries suffered by athletes, have effects similar to rheumatism, fibrositis, "lumbago" and neuritis, which take up a majority of the medical profession's time. Though an athlete can give up athletics to effect a cure, the middle-aged housewife cannot give up her chores. Chronic strains may result from compensation resulting from minor injuries.

Patients might benefit from athletic training to overcome such conditions as an osteoarthritic hip and similar disabilities set off by minor injuries.

Perhaps "sports medicine" can answer questions about strength of muscle-groups which act on a joint, and their relation to injury, the suppleness of that joint and factors affecting joints under stress.

"Sports medicine" may provide answers about the extent to which our well-being depends on the mechanical and functional efficiency of the body.

Total Body Cooling

General body cooling has been tried for the first time in stopping massive bleeding in the stomach and intestinal area and found successful, according to Gowen and Lindenmuth, who describe three cases in which massive hemorrhages were controlled by the method.*

"Although general hypothermia has not been used previously for patients with massive gastro-intestinal hemorrhage, the background of experience in other conditions gave evidence for its use," the authors said.

The severity of the bleeding may be judged from the fact that 62 pints of blood were replaced in one patient before hypothermia, 33 pints in another, and 14 pints in the third.

Ice bags were applied to lower the patients' temperatures to 88 degrees Fahrenheit. The duration of hypothermia varied.

"The exact mechanism by which gastro-intestinal hemorrhage was controlled in these patients is not known, but the prompt improvement seems more than coincidental. Certainly in the poor-risk patient with massive uncontrolled hemorrhage, total body hypothermia would warrant further evaluation. And in each of the three cases, operative intervention was clearly inadvisable."

There was no recurrence of the bleeding, although one of the three patients died later.

*January 7, 1961, Journal of the American Medical Association.

Marvin L. Bierenbaum, M.D.

Donald P. Green, M.D.

Anne B. Caldwell, Ph.D.

Elizabeth H. Kelly, M.S.

Montclair

Blood Cholesterol and Coronary Heart Disease*

Preliminary Report

We Americans are accustomed to a 40 per cent (by caloric) fat ratio in our diets. We can thrive on 30 per cent and find it palatable and healthy, as reflected in this collaborative study.

The relationship, if any, between cholesterol and coronary disease, has been a subject of great interest lately. At St. Vincent's Hospital, Montclair, we began, in October, 1959 a study of the effects of a low fat diet (relatively high in polyunsaturated fatty acid) on the blood cholesterol of men in the 20-to-50 age bracket who had had previous myocardial infarctions. This was a special research project of the Heart Program, Division of Chronic Illness Control, New Jersey State Department of Health. This work had been stimulated by that of Jolliffe and Rinzler [1] who had reported on the effect of a similar diet on blood cholesterol levels of "high coronary risk" middle-aged men in New York City. This age group was selected because of expected longer survival than their older counterparts and, perhaps, reversibility of arteriosclerosis. This is a preliminary report on the first six months of experience with 75 men who have been evaluated and started on dietary management.

*From St. Vincent's Hospital, Montclair and the Division of Chronic Illness Control, N. J. State Department of Health.

1. Jolliffe, N., Rinzler, S. H. and Archer, M.: American Journal of Clinical Nutrition, 7:451 (July, 1959).

2. Kinsell, L. W., *et al.*: Journal of Clinical Endocrinology, 12:209 (1952).

3. Ahrens, E. H., *et al.*: Journal of Clinical Investigation, 34:918 (1955).

4. Jolliffe, N.: New York State Journal of Medicine, 57:2684 (1957).

HISTORICAL BACKGROUND

In 1952 Kinsell *et al.*[2] showed that under metabolic ward conditions the substitution of polyunsaturated fatty acids for dietary saturated fatty acids would lower the blood cholesterol. Since then, there has been great interest in the dietary approach to management of blood lipids and possibly to the control of arteriosclerosis. Ahrens *et al.*,[3] three years later, confirmed these observations using polyunsaturated fatty acids. Jolliffe [4] in 1957 stated that enough evidence existed concerning the relationship of diet to heart disease to establish clinical study for public health gain. Following

through on this premise, a preliminary study in 1959 by Jolliffe and Rinzler[1] showed that of 79 men followed for 6 months on such a diet, there were significantly lower blood cholesterol levels than from base-line readings. Page *et al.*,[5] attempting to lower blood cholesterol by chemical means, were successful using Benzmalacene®; but after four months of treatment they noted deterioration of liver function and urged extreme caution before long-term clinical trials be undertaken. Stamler,[6] in 1960, pointed out that dietary management alone in either of two ways (1) by use of diet low in total fats-cholesterol, or (2) by use of oil-containing diets moderate in total fat content and low in saturated fats and cholesterol would usually lower blood cholesterol levels. With this background, this study was designed to determine whether patients can be motivated to follow a change in dietary plan to 30 per cent calories as fat. The usual American diet is 40 per cent or more calories as fat. We also sought to appraise the effectiveness of dietary treatment in the reduction of recurrent attack rate of the study group.

APPROACH TO THE PROBLEM

To recruit patients for the study group, private practitioners in the area were appraised of the project and of its support by The Medical Society of New Jersey and its component county societies. They, in turn, referred patients. Also, announcement of the project was made in local newspapers and over local radio stations. Since that time, a steady influx of new patients has kept the project moving actively toward the desired number of 100. Prerequisite for acceptance was that the patient be a male between the ages of 20 and 50 and have had one or more myocardial infarctions as proved by the electrocardiograph. Grounds for exclusion from the project were: (1) Any non-cardiovascular disability likely to cause death within two years; (2) Chronic alcoholism; (3) Elevated blood urea nitrogen above 60 milligrams per 100 milliliters; (4) Malignant hypertension; (5) Uncontrolled cardiac failure; (6) Recent cerebrovascular accident; (7) Valvular disease of the heart; (8) Insufficient time for regular attendance.

Patients meeting these criteria were invited in small groups to an indoctrination meeting. There the purpose, functions and scope of the project were discussed and questions answered. The patients were advised that they would remain under the care of their private physicians and that all information obtained would be available for their subsequent management if desired. This has fostered a cooperative spirit by the treating physicians. The patients were also advised that this was a research project in addition to being a primary service project of the state heart program and that the expected duration would be five years once the entire group had been recruited.

At the time of the initial history and physical examination, a record was made of all treatments that the patient was getting (anticoagulants, nitrites, digitalis, antihypertensive drugs, and so on). Using this information, cases were assigned on a random basis either to diet Group I or diet Group II. Both diets were at 30 per cent fat of total calories. In Group I, part of this fat allotment was in the form of liquid oily supplement. The patients then had x-rays of chest, abdomen and legs, directed particularly toward soft tissue. Other laboratory studies included fasting blood sugar, blood urea nitrogen, complete blood count, urinalysis and electrocardiograph. The blood cholesterol level was first obtained on three consecutive weeks to establish a "benchmark level" and then repeated at frequent intervals. (All cholesterol determinations were done in duplicate by the Anderson-Keys[7] modification of Abell's method.[8])

During this preliminary study, before any dietary instruction, the patient kept a seven-day food diary which was evaluated by the

5. Page, I. H. and Schneckloth, R. E.: *Circulation*, 20:1075 (1959).

6. Stamler, J.: American Journal of Public Health, 2:14 (March, 1960).

7. Anderson, J. T. and Keys, A.: Clinical Chemistry, 2:145 (1956).

8. Abell, L. L., *et al.*: Journal of Biologic Chemistry, 195:357 (1952).

project nutritionist to determine the composition of carbohydrates, protein, minerals and vitamins as well as the amount and quality of fat utilized. This information was also used in preparing a separate "hand-tailored" diet for each patient. With the completion of this basic information, and in the presence of patient and spouse, the data were reviewed by the project physicians who determined whether weight reduction was needed. All overweight patients were placed on weight reduction, whether in Group I or Group II. This diet was continued until desired weight was reached. The patient then went on a 30 per cent fat diet and joined the group to which he had been assigned. The 30 per cent fat content was achieved by elimination of certain dairy products, rich desserts, certain fried foods and fatty meats. Group I received one ounce of corn oil as part of the 30 per cent fat allowance. Both diets are planned to furnish amounts of minerals and vitamins needed to fulfill recommendations of the Recommended Dietary Allowances of the National Research Council.

During the initial ten-week period on weight reduction and/or low fat diet, serum cholesterol determinations were obtained bi-weekly. The patient was weighed and he was interviewed for any dietary problems that had arisen. If necessary, the patient and his wife met with the nutritionists; but generally the patient was re-interviewed at the end of ten weeks by the project physician panel and the nutritionists. Thereafter, cholesterol determinations were obtained every ten weeks or at the time of changing from weight reduction to 30 per cent low fat diet. At the end of one year, each patient will be restudied as at the time of admission to the project.

RESULTS

USING the tertile distribution of cholesterols of Jolliffe and Rinzler,[1] which was consistent with the cooperative study of Gofman *et al.*,[9] it was found that (out of the 32 patients who had been in the study for a long enough period to evaluate the effects of ten weeks on the low fat diet assigned) 9 patients were above 270 milligrams per cent, 10 patients were in the mid-range; and 13 patients were below 230 milligrams per cent. The cholesterol average for all 32 patients was 253 milligrams per cent (190 to 378).

Table 1 shows blood cholesterol levels at the start of low fat diet and at the end of a 10-week interval for 32 patients at ideal weight. Of this group, 14 had a prior period of weight reduction, during which they achieved the "ideal weight." Cholesterol levels are reported graphically according to tertile, with slight variation from initial "benchmark" on the weight reduction program. Eighteen patients were followed on diet I (with oily supplement); 14 patients were maintained on diet II. Although differences of the order of 20 milligrams per cent were observed, the statistical significance level of the data is somewhat low. However, the agreement between our data and that of Jolliffe, Rinzler, and Archer[1] was excellent (See Table 2). It appears that to detect differences of the order of 20 milligrams per cent with confidence, apparently twice the present number of patients will be needed. This will be done in a more extensive report subsequently. There appeared to be no appreciable difference in the effects of diet I and diet II on blood cholesterol levels during this study period. A statistical evaluation is shown in Table 3.

COMMENT

A NUMBER of very interesting facets in the management of patients on diets and on weight reduction have presented themselves. For one thing, despite rather severe dietary restrictions in some cases, there has been no drop-out from this project to date. This has been attributed to the extremely close relationship of both physician and nutritionist to the patient and points out the many psychologic factors which come to play in any diet

9. Gofman, J. W., *et al.*: *Circulation*, 14:691 (1956).

TABLE 1.

COMPARISONS BETWEEN "START OF TEST" AND "10-WEEK" CHOLESTEROL LEVELS:

	No. in Test	Average Start of Test	Average 10 Wk.	Diff.	Standard Deviation Start of Test	Standard Deviation 10 Wk.	D	t	P
Group I	18	239.4	219.8	19.6	42.2	32.3	12.5	1.6	0.15
Group II	14	256.8	237.4	19.4	42.9	34.6	14.7	1.31	0.2
Group I and II	32	247.0	227.5	19.5	42.7	34.0	9.64	2.02*	.06*

*Probably significant (94% confidence)

TABLE 2.

AGREEMENT BETWEEN ST. VINCENT DATA AND DATA OF JOLLIFFE, RINZLER, AND ARCHER

	Initial Average	Initial Standard Deviation	10 Week Average
St. Vincent	247.0	42.7	227.5
Jolliffe, *et al.*	251.3	42.2	232.1*

*2-month data

TABLE 3.

AVERAGE CHANGES OVER TEN WEEKS

	No. in Test	Average	Standard Deviation
Diet I	18	19.6	28.3
Diet II	14	19.4	41.3
Diff.		0.2	

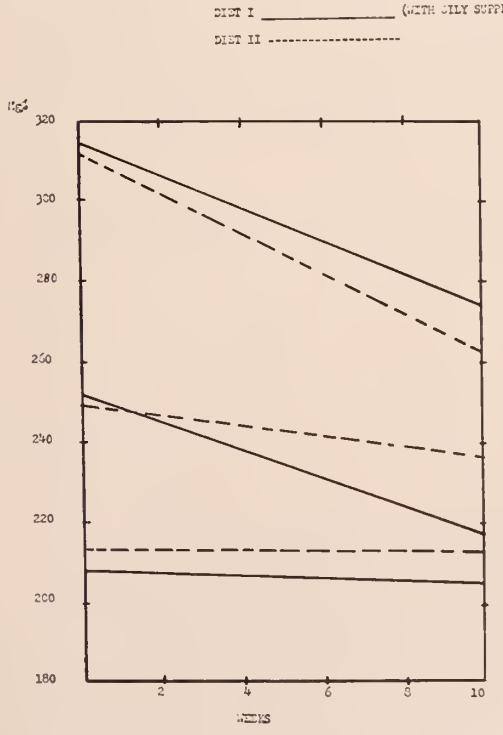
STATISTICAL EVALUATION

D = 6.0
t = 0.03
P = Not significant

restriction. In addition, to date there has been almost 100 per cent performance rating in weight reduction in spite of the fact that the subjects were free living and taking meals at home and in restaurants. (Weight reduction will be discussed in more detail in a subsequent paper.) No medications have been used and the only tools applied have been the extremely close dietary supervision of the nutritionist of a "hand-tailored" diet taken from the dietary history provided by the patient. Apparently because of the frequent revisit and dietary recall and the intense motivation of the patients who have experienced the distress of one or more myocardial infarctions, there has been no slipping back to old dietary habits and of weight gain.

Despite the small number of patients studied to date, it appears probable that a 30 per cent fat diet is capable of lowering blood cholesterols significantly, with greater numbers needed for absolute confirmation. However, the agreement of our data with the results of Jolliffe, *et al.*,[1] is highly encouraging and gives further impetus to the continuation of our study.

Failure to demonstrate any difference between diet I (with oily supplementation) and diet II is surprising in view of earlier reports of increased effect of the polyunsaturated oil supplements. However, the numbers



THE AVERAGE CHOLESTEROL RESPONSE BY TERTILS OF PATIENTS ON DIETARY REGIMEN FOR TEN WEEKS

are very small and perhaps the figures will show a difference with time. Even more important is that some question is raised as to the efficacy of our diet I in doing what it was hoped it would do. Further thought must be given to the possible increase in the amount of polyunsaturated fatty acid in the diet, along the lines of Page and Brown,[10] to produce a further decrease in blood cholesterol levels; especially since Stamler[6] suggested that the cholesterol lowering effects of our two diets might be the same or very little different. Further evaluation of this critical point will be necessary. Finally, during the ten-week period reported there was no new occurrence of myocardial infarction in the study group; but it is far too early to attach significance to this.

SUMMARY AND CONCLUSIONS

1. A 30 per cent by calorie fat diet, with or without oily supplement, appears to be a satisfactory, palatable, and acceptable regimen to free living, adult males over a prolonged period of time.

2. The average cholesterol "benchmark" of 32 males with one or more myocardial infarctions, age twenty to fifty, was 253 milligrams per cent (190 to 378 milligrams per cent).

3. After ten weeks of dietary management there appeared to be no difference between the cholesterol response of the two groups (with or without liquid oily supplement), there being an average drop of 20 milligrams per cent in each group.

4. The statistical validity of both these conclusions requires further corroboration; and the question of further increasing oily supplementation to diet must be strongly considered.

ACKNOWLEDGMENT

The authors gratefully acknowledge the assistance and encouragement of Dr. Roscoe P. Kandle, New Jersey Commissioner of Health; Dr. Alvin Florin, Program Coordinator, Heart Disease Control Program, New Jersey State Department of Health; Dr. Charles Gherman, Heart Disease Public Health Physician; and Mrs. Margaret Zealand, Nutrition Consultant, New Jersey State Department of Health. Also, sincerest thanks are offered to Dr. Andrew Dingwall for his able statistical analysis. In addition, acknowledgment is made to Dr. Seymour Rinzler and Dr. Norman Jolliffe for their early encouragement and many useful suggestions. The authors' sincerest thanks are extended to the Corn Products Company and the Dannon Milk Company for their generous and far-sighted support in supplying many products and equipment used throughout the study. It is also a pleasure to acknowledge the excellent contribution of the members of the laboratory and x-ray staff of St. Vincent's Hospital, Montclair, N. J., in providing the vital physical data and to acknowledge the wholehearted support of Sister Clare Delores, R.N., Administrator of the hospital. Finally, thanks are most gratefully extended to Mrs. Sandra Prager for her invaluable help and allegiance to the project in its many facets.

45 Elm Street

10. Brown, H. B. and Page, I. H.: Journal of the American Medical Association, 173:248 (May, 1960).

Drug Addicts Look Normal

Drug addition is found 4 times more often in men than in women, according to *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession. Of the country's estimated 46,226 addicts, 79 per cent are men.

Moreover, as *Patterns* points out, addiction is primarily a problem of the young. More than 7 out of every 10 addicts are under the age of 30 and of these, 12 per cent are under the age of 21.

How young is the person who starts taking the drugs? According to one study of 300 patients cited by *Patterns*, 45 per cent were 19 and under when they first became addicted, and an additional 44 per cent were in the 20 to 29 age group at the time of the onset.

Ira S. Ross, M.D.

South Orange

Public Health Aspects of Private Practice of Psychiatry*

In this eloquent plea for better support of medical schools, Dr. Ross also makes some gloves-off criticisms of other facets of public health care.

Movements make history; they do not necessarily make progress. The current movement of lay organizations in the field of mental health is toward the elimination of the private practicing psychiatrist as the main bulwark against the progression of mental disease. This is being carried forward upon the false notion that it is possible to economize upon the training years that are needed to make a psychiatrist. There exists a widespread notion that it is possible to train technicians without medical education to treat sick people. In the field of mental health we repeatedly hear the statement that "psychotherapy is not the province of the physician." As a result, people with disordered brain function are being treated by individuals to whom the brain is a black box whose anatomy and physiology have no relation to mental disorder.

Three committees of consultants appointed respectively by the Secretary of Health, Education and Welfare, United States Surgeon General and the United States Congress have in the past three years reported on problems of medical research and education. Although each of these differed in detail, they all agreed on one thing. Unless immediate action is taken by private and public agencies the number and quality of America's physicians will decline to a point where the nation's health is endangered. This conclusion is based on the key assumption that the ratio of physicians to population must not fall below today's ratio of 141 physicians (one hundred thirty-two M.D's. and nine doctors of osteopathy) for each one hundred thousand Americans. For the past thirty years that ratio has scarcely changed. It remained stable, however, only because it included more and more foreign doctors. Last year 8,400 foreign physicians from 91 countries served in 846 United States Hospitals. (In 1950 there were 458 foreign doctors in the United States.) The imminent shortage of physicians becomes more significant and more sobering when we turn to the source of our doctors: the supply of medical students. The number of students applying to the nation's medical schools has dropped steadily for the past three years. There are no national scholarships for medical students.

The Bane report for the United States Surgeon General, 1959, "Physicians for a Growing America," warns if we are to have enough physicians by 1975 we must expand existing educational facilities and build 20 to 24 new medical schools. Dean Thomas Turner of the Johns Hopkins Medical School believes "that the real bottleneck in medical education today is in the lack of qualified teachers and scientists to staff the basic science departments of

*Read October 26, 1960 at the New Jersey Welfare Council meeting in Asbury Park.

medical schools." Lee Powers, Associate Director of the Association for American Medical Colleges states: "Inadequate financing has imposed a continuing threat to the nation's medical schools. Always in the past the schools have found solutions to meet the needs of the recurrent crisis. However, there is a lapse of eight to ten years between the planning of a medical school and the graduation of the first class (which then faces internship, residency and military service)."

THERE is only one medical school in New Jersey. The so-called backward southern states, including Oklahoma, Arkansas, Louisiana, Tennessee, Mississippi, Alabama, Georgia, Florida, South Carolina, North Carolina, Virginia, and Maryland, all have State Medical Schools. Five years ago a bill to provide funds for a State Medical School in New Jersey, died in the Legislature for the want of an increase of one cent in the state cigarette tax.

Private fund raising for medical agencies has reached the $1,000,000,000 mark. There are upwards of 100 national agencies collecting funds on a private basis. A recent Rockefeller report states that less is known of this industry than any other comparative financial undertaking in the country. There is little or no knowledge as to the use of these funds. The physician is continually under pressure as he must serve both as physician and policeman for existing hospital and medical service plans.

The consideration of funds available to medical schools gives an idea of the overall crisis in medical education. The combination of funds received from tuition and endowment reaches some 34 million dollars; miscellaneous income, 42 million, gifts and grants, 27 million, but general university funds and state appropriations provide 76 million toward the income for expenditures of 78 United States Medical Schools. Funds earmarked for research reach 91 million, and there simply are not sufficient qualified researchers to utilize the funds available for medical research.

Private practicing psychiatrists make up the present bulwark against mental disease. There are approximately four hundred psychiatrists in New Jersey of whom about one hundred are in institutional, clinic and administrative work. The remaining three hundred are in private practice.

THE major break-throughs in the treatment of mental illness in the last thirty years have been the use of insulin for schizophrenia, electroshock for the depressive disorders and the later development of chemicals as powerful tools in the treatment of both of these diseases. It is, of course, necessary to understand the nature of the mental processes that are disordered in serious mental sickness so that the afflicted may be treated wisely and humanely. The bulk of the patients in mental hospitals today are not amenable to psychotherapy alone. The public should know that. The first reversal in the increase of admissions to state mental hospitals followed the introduction of electroshock therapy. Electroshock therapy has had a bad press. The cost of medical liability insurance to a psychiatrist using electroshock has increased four-fold, largely because of this adverse publicity. However, thousands of people each year are spared compulsory admission to state mental hospitals because there are psychiatrists in private practice courageous enough to relieve suffering, effect cures and keep breadwinners at work in spite of the sneers and jibes of the psychologic purists and the responsibility that goes with the treatment.

The tranquilizers have had a bad press. Every new drug that hits the market is headlined as a producer of liver and blood disorder; but more cases of "poisoned blood" are produced by the acetanilid derivatives that can be bought across the counters of drug stores all over the country without prescription and in super markets and department stores as well. It was only with the advent of chlorpromazine that the resident populations of the state mental hospitals have begun to be reduced.

The misguided notion that psychotherapy alone is going to stem the tide of the inflow to mental hospitals should be corrected. There is no decrying the value of psychotherapy in helping the misguided, the unloved, the uneducated, the rejected, the adventurer, the overambitious, the fearful, the impotent and the overcompensated; but most of those people, whose suffering and inadequacies need treating by psychotherapy, would somehow muddle through without ever needing a state mental hospital. I know of no public clinic that offers electroshock therapy. I know of no private psychiatrist who gives electroshock who does not give treatment at clinic rates when occasion merits. Furthermore, the trend is growing to keep ambulatory treatment problems who are being helped with psychotherapy on psychopharmaceutical drugs. This cannot be done without medical training.

THERE are many varieties of private practicing psychiatrists. They range from neuropsychiatrists, like myself, who deal with physical as well as functional disorders of the nervous system to general practicing psychiatrists who use drugs, electroshock, insulin and psychotherapy in treating functional disorders alone to psychoanalysts who treat a narrow range of selected problems by psychoanalytic technics usually without any medication. There is need for all. The private practicing psychiatrist holds himself out directly responsible to the public. As soon as he sees a patient he becomes personally liable medically, morally and legally for that individual's health. The rule of *caveat emptor* goes by the board. The physician becomes liable for any treatment not in keeping with the standards of the psychiatrists in his community. His patient sees him personally. He takes his own history if he knows what is good for himself and his patient. He examines his patient physically and mentally. He knows when to ask for help and specifically what kind of help and what it is going to cost and in so doing involves as few people as possible. There is no premium upon having useless personnel around to do esoteric tests. People who pay for what they get are wary about that sort of thing.

Last year, at a meeting of the Community Mental Health Advisory Council, I asked what I considered a simple question: "Should every patient who is seen at a clinic sponsored by a County Mental Health Board and the State Department of Institutions and Agencies be seen by a psychiatrist at least once?" To my surprise not one other member of the board agreed with me. I do not feel that any clinic should be dignified by the use of the term 'psychiatric' where it is possible for a patient to be admitted and discharged without ever having been examined personally by a psychiatrist. Furthermore, I shall do whatever is in my humble power as a private citizen serving in a public cause, representing no other organization than the structure of my conscience, to see to it that my neighbor's money is not spent upon something that has a phoney title. If the powers that be want clinics without psychiatrists, then they should fly an appropriate flag at the masthead. Do not call them psychiatric clinics. I should like each publicly funded clinic to be known by the name of its chief psychiatrist. Pride would insure a personal touch. The patient would know who bore him responsibility.

What does it take to train a psychiatrist? How much does it cost? Where can he be trained? What can he give to the community when he has been trained and functions efficiently? I shall answer these questions briefly in reverse order.

AN EXPERIENCED neuropsychiatrist may see between three and four hundred new patients a year. No one comes to his office unnecessarily. No one need be charged exorbitantly. Patients are kept at work, out of state-supported mental hospitals. The private practitioner has no tax exempt structure and income tax dollars go back into the federal funding of public mental health projects. He pays taxes on his home and office. Staff members of county and State Hospitals live in tax free

properties. Public hospitals and clinics pay no property taxes.

The private practicing psychiatrist functions on community mental health boards, teaches without pay for the honor of serving the cause at local medical schools, talks to lay groups. The private practicing psychiatrist has no professional mendicant out to raise funds for him. The fact is he is solicited early and often and has a special place on the list of donors who are known to be interested in the cause of mental health. For this he is accused of having a vested-interest. It is a healthy thing to have a vested interest in that by which we live. Responsibility and personal ownership go hand in hand.

Vice-President Nixon has pointed out the value of the 27 per cent that constitutes the exemption upon profits from oil wells for income tax purposes. He feels that this is the stimulus necessary to invest the money it takes to find new oil wells. Oil is the liquid gold of modern day civilization. I will tell you where money should be invested to produce oil, liquid gold, or, as Robert Louis Stevenson phrased it, the flower of modern day civilization, the Physician. Scholarships must be made available for young people who have the ability, the drive, the perseverance, the human interest to live through the long training years that make a psychiatrist. There is no substitute. Wisdom cannot be substituted by *ersatz* five-year wonders. It takes maturity to study medicine. It takes four years of college to begin to acquire that maturity.

Our young people are confronted with the choice of some 250,000 different occupations. It is fallacious to feel that anyone can guide the twelve hundred students of the average junior high school. However, those who wish to be scientists should be encouraged to follow a medical career and scholarships should be made available to them to do so. Our young people are not as mature as their parents were when they were their same ages simply because the world is more complex. It takes four years to complete medical school. There is growing importance to the preclinical science training. Medicine of the future requires a better understanding of the anatomy and physiology of the brain and its relationship to the organization and function of the body than ever before. The disorders of the future are not those of the bacterial diseases. The day of the great scourges is past even in the jungles. The stresses and strains of occupation and environment weighed against biologic endowment and nourishment, both physical and emotional, throughout a prolonged period of childhood dependency will determine the disease incidence of tomorrow.

I do not agree with Dr. Conant's view that a crash program for the greater cramming of knowledge into the quiz kid ten per cent is what our country needs for survival. I remember a professor of surgery who used to say he could train any newsboy to perform surgical procedures, but that it took seven years of residency to give a man the judgment needed to know when to operate. It is possible to teach advanced mathematics and electronic engineering to a select few and get them to make rockets that will go to the moon or blast our enemies and ourselves off the face of the earth; but it will take maturity to keep fingers off the panic button and know when not to push it.

IT TAKES a year of internship, three years of approved residency and two years in practice of psychiatry, or five years of residency, to qualify a man for his specialty boards in psychiatry. After passing the examination given by the American Board of Neurology and Psychiatry, the doctor is entitled to a diploma that certifies him as a specialist. Thus, there are fourteen years of training necessary today to qualify as a certified psychiatrist. To become a psychoanalyst, it is necessary to complete a personal training analysis and to psychoanalyze two patients under the control of a member of the American Psychoanalytic Society. At the present rate of tuition and expense, figuring three thousand dollars a college year, it is going to cost twenty-five thousand dollars or thereabout to put your child through a training course to help him

become a psychiatrist; and then he will only be at the beginning. Maturity comes much later. It does not come in the hospital; it does not come in the comfortable structure of the clinic with all the ancillary help available and where the name of the clinic is the symbol that attracts the patient. Maturity comes when the patient seeks out the psychiatrist by name and pays him a fee personally for what he can do. It is then that a physician feels humility and the limitation of the power of all of his knowledge. Face to face and personally responsible to the patient there are no latter day saints to promise life immortal on this earth, "Rehabilitation for everyone and everyone rehabilitatible."

Death comes to everyone and that is a fact of life. Some diseases are incurable and that is a fact of life. It is not kind nor honest nor humane to make braces for the hands of a patient with amyotrophic lateral sclerosis and send him to occupational therapy three times a week on the assumption that he is going to learn something to do with fingers that are never going to move again. That happened to a patient of mine at a prominent rehabilitation center just two weeks ago.

When we hold out more than we can offer, when we promise more than we can fulfill, when we offer rewards or even implied rewards for being sick that are greater than those obtainable we are creating an environment for mass hysteria, for the unconscious release of hostility by self-maiming and authority-blaming that will create a public health hazard the likes of which this country has never seen. The greatest function for the public health of this nation that the private practicing psychiatrist can perform is to make the public aware of the shortage of medical schools, the need for medical scholarships, the need to invest in the gold standards of human beings. This wealthiest country in the world can afford to give money to young people who will follow the holy grail of the long road to maturity through study; not hurried crash programs but *study* as the essence of living itself; and that means time for work, time for play, time to grow, time to love and raise families in the process. Whether the money comes from the new billion dollar industry or fund raising described by Paul Lancaster in the *Wall Street Journal* on October 11, 1960, or the drug firms who have more money to give for research than there are researchers trained to do the work (according to the *Johns Hopkins Magazine* of October, 1960) or from local, state or federal funds, religious or civic organizations, all of which sources are untapped in this great nation, the money must be forthcoming or our society as we know it will not long survive.

179 Irvington Avenue

Not Enough Nurses

The number of nurses in this country has multiplied rapidly over the past few decades, but a shortage still remains, according to the July 1960 issue of *Patterns of Disease*, published by Parke, Davis and Company.

"Although the number of professional nurses has increased 2½ times since 1920, still more are needed to meet present demand," *Patterns* reports. "Positions are unfilled, wards close for lack of nurses, and many counties lack a public health nurse."

In 1958, for instance, about 11 per cent of full-time nursing positions in hospitals were vacant. However, individual hospitals may find the situation "more critical," *Patterns* points out. Thus, one large city "has reported that only 42 per cent of the budgeted positions for professional nurses in its Department of Hospitals are filled."

There are now 270 active professional nurses per 100,000 population. Estimated as necessary are 300 nurses per 100,000 population, as desirable, 350.

Trustees' Meeting: January 15, 1961

The Board of Trustees met in Trenton on January 15, 1961. Actions taken included the following:

MSP PUBLIC RELATIONS COUNSEL

A report was received from the special committee on MSP public relations. The following recommendation was adopted by the committee: That Medical-Surgical Plan of New Jersey employ its own PR Counsel, separately compensated by, and exclusively responsible to, Medical-Surgical Plan. It was the belief of the committee that such an action can be carried out without the development of serious variance with the terms of the joint operating agreement betwen MSP and HSP. This recommendation will be presented to the MSP Board.

Action: That the special committee of MSP be commended for its excellent report.

PERINATAL MORTALITY INSTITUTE

The Board authorized the Society's co-sponsorship of this Institute with the State Department of Health, as recommended by the Committee on Maternal and Infant Welfare. An official invitation was received on January 12, and a letter of acceptance was sent by the President that same day.

HEALTH SCHOLARSHIP PROGRAM

An invitation has been received from the National Foundation to nominate three physicians, of whom one will be invited to serve on the state selection committee.

Action: The following nominations, in order of preference for appointment, were approved: (1) Dr. Bowers; (2) Dr. Butler; and (3) Dr. McCall.

AMA DUES INCREASE

Referred for the Board's attention was a communication from Dr. Costello, chairman of our AMA delegation, from a Camden County member protesting the proposed increase in AMA dues.

Action: That Dr. Costello be advised to tell the member to take the matter up with his component society and request it to take action as evidence of strength and forward such action through regular channels — to the Board of Trustees or the House of Delegates — for action at State level.

STATE LEGISLATION

Two pieces of amending legislation are ready for introduction. (1) The amendment to the *School Examination Law* for acceptance of the family physician's examination in lieu of the examination by the school physician; and (2) the amendment to the Medical Practice Act for the legal protection of *x-ray and medical technicians*. It would be advantageous to have a statement of purpose in the bill, and with the cooperation of the Legislative Analyst such a statement was prepared. Mr. Nevin read the statement and requested that it be approved by the Board.

Action: One word (legal) was eliminated, and the following amended statement was approved:

> This amendment is intended to adjust the Medical Practice Act to the expanding modalities of medical care by affording legal protection to those individuals who supply technical ancillary services to licensed physicians, and whose services are not presently encompassed in the provisions of the Medical Practice Act. The provisions of this bill will permit the rendering of such services under circumstances insuring maximum protection to the public.

N. J. CHAMBER OF COMMERCE

The Executive Officer has been invited by the Chamber to participate in weekly legislative conferences in Newark. This will be an opportunity to get the point of view of the Chamber and to let them know of the Society's views on certain pieces of legislation. Mr. Nevin has accepted the invitation.

MEDICAL DEFENSE AND INSURANCE

A loss control program text approved by the committee and representatives of American Mutual, in connection with the Society's program of professional liability insurance, was offered to the Board for consideration and action.

Action: The program as presented was adopted.*

MEDICAL STUDENT LOAN FUND

With the restriction of not disbursing in excess of 20 per cent of the total fund on hand in any one year, and with the limited contributions being received, the amount which will be available for loans to medical students for their 1961-62 school year will be below that which will be required. At present it appears that only $8,000 will be available for loans, while requests are anticipated at more than $15,000.

Action: The Board authorized transfer to the Medical Student Loan Fund, on loan without interest, all monies in excess of $100,000 in the Surplus Account at the end of this fiscal year. The amount thus assigned will be at the disposal of this committee for 1961-62.

The Administrative Secretary was requested to prepare and submit at the next Board meeting an account as to the result of the action and how it will affect next year's loans.

Dr. Featherston suggested that the action be given serious study before the Annual Meeting to evaluate the financial needs of this program. It might be possible to have these needs covered by an annual budget allocation.

ROSTER OF SCHOOL PHYSICIANS

In accordance with the Board's directive that the Secretary investigate the possibility of obtaining "a roster of school physicians . . . with a mechanism for maintaining changes in personnel as they occur," a current roster has been obtained from the State Department of Education which revises its list every three years. It was learned from the Department that "maintaining changes as they occur" is an impossibility with 577 school districts to keep track of.

Dr. Greifinger suggested that the Executive Offices contact the State Department and arrange to alter our roster every three years from the information obtained by the Department.

Action: Suggestion approved.

STATE BOARD OF MEDICAL EXAMINERS

A communication from the Governor requested an additional list of three names for the vacancy caused by the expiration of Dr. Weigel's term so that he might consider these along with the three previously submitted.

Action: The following names are offered:

1. John A. Kinczel, M.D., Trenton
2. Elmer J. Elias, M.D., Trenton
3. Joseph M. Keating, M.D., Passaic

MENTAL HEALTH CONFERENCE

The Society was invited to send representatives to the annual Mental Health conference in Chicago, January 20, 1961.

Action: That the chairman of the Special Committee on Mental Health, Dr. Mackin, be authorized to attend the conference as the society's official representative with expenses paid.

MEDICARE CONTRACT

A supplemental agreement to the Medicare Contract has been reviewed by the committee. It deals with administrative costs and is subject to acceptance by the fiscal agent, Medical Service Administration.

Action: That the proper signature on the supplemental agreement be authorized when the document is officially received.

*See page 146 this JOURNAL.

Loss Control Program

A Loss Control Program is fundamental to the success of a group professional liability insurance project. Success can be attained only through close cooperation of the group and its insurance carrier and representatives. It calls for reciprocal understanding of the many and complex problems involved in the handling of malpractice claims.

The *purpose* of the Loss Control Program is, by studying and evaluating claims submitted and complaints filed and by reviewing the disposition thereof, effectively to process claims and to determine why they originate.

MEDICAL REVIEW AND ADVISORY COMMITTEE

The Loss Control Program will be effectuated by means of a Medical Review and Advisory Committee maintained by each component society. It is recommended:

1. That the members of the Medical Review and Advisory Committee be appointed by the president of each component society and confirmed by the executive committee (or its equivalent) of the county society or the county society as a whole.
2. That the committee consist of no fewer than five members, with adequate representation of specialties, including general practice.
3. That one member of the committee may be a non-physician of recognized stature (e.g. an outstanding clergyman) in the community.

Responsibility: It is the responsibility of the Medical Review and Advisory Committee to investigate and evaluate the medical aspects of claims and complaints to determine the facts, and to make recommendations. The committee should report at least once a year to the members of the component society — and more frequently to the Committee on Medical Defense and Insurance — all observations and recommendations arising out of the committee's experience.

Meetings: Meetings should be on a regular schedule in the large societies; smaller societies should convoke meetings as need indicates. Each sitting of the Medical Review and Advisory Committee will be attended by representatives of the insurance carrier and by the company's legal counsel.

Agenda: The agenda will be prepared by the representative of the insurance carrier, and — (having been approved by the committee chairman) — distributed to the Medical Review and Advisory Committee two weeks in advance of the next meeting.

Disposition: Disposition of matters before the Medical Review and Advisory Committee shall be arrived at by vote of its members.

In consequence of its investigation of a claim or complaint, the committee shall then make a recommendation to the insurance company concerning the medical defensibility of the matter.

When a claim is to be defended, the committee should assist in getting medical testimony.

Mr. Vanderwater declared that the company would unequivocally accept and support the program as worked out at the meeting on January 11, 1961, in Newark.

Honor for Hilton Read

For his efforts to wage peace through a medical hands-across-the-sea program, Hilton S. Read, M.D., was given the 1961 Brotherhood Award of the Atlantic County Brotherhood Council on February 20.

At a meeting preceding this award, Dr. Edgar H. Reichel presented I. S. Ravdin, M.D., Professor of Surgery and Vice President for Medical Affairs, University of Pennsylvania, with the Officers' Cross of the Order of Merit of the Federal Republic of Germany. Dr. Reichel acted as a representative of the President of the Federal Republic of Germany, and presented Dr. Read with the Officers' Cross of the Order of Merit of the Federal Republic of Germany.

Since 1951 The Ventnor Foundation has brought 600 recent graduates of central European medical schools to selected community hospitals in New Jersey, Massachusetts and Pennsylvania for a year of rotating internship.

LIABILITY INSURANCE

You Are the Patient

Doctors, today, are not treating patients with the same drugs or operative procedures you used 35 years ago. You have progressed, during those years, to an up-to-date science as practiced today. Likewise in insurance, there must be progress, improvements and new ideas if the patient (the insured doctor) is to have the best care with the best result available.

The subject of professional liability insurance is vital to every member of the medical profession, not only in terms of financial protection against any claim but, more important, as protection for his professional reputation. The average individual who has never needed an operation or one who hasn't needed any medical attention, doesn't appreciate the advances of medical science. Very few doctors have ever experienced the need for insurance and, therefore, do not appreciate the advantages of one company or its program until the test comes. By then it may be too late, if there isn't some person or organization to intercede for him.

In 1960 your House of Delegates endorsed the American Mutual Liability Insurance Company and its program for the writing of professional liability insurance for the members of The Medical Society of New Jersey. This was the first American liability insurance company. It was founded in 1887. Today the annual premium of its group is approximately $100,000,000. It is a mutual company whose policies are guaranteed non-assessable.

American Mutual will not write this insurance in every state because it is such a highly specialized type of coverage. To be successful for all concerned, a program must be followed which has proved highly successful in California. This program was endorsed by The Medical Society of New Jersey. One of the features is that all important decisions are arrived at, after full discussion of the matter with your State Committee on Medical Defense and Insurance.

Cancellations, underwriting and renewals follow a basic pattern with most insurance companies: but the pattern of *this* plan is followed by only one company: the American Mutual. The plan is to insure any member in good standing of The Medical Society of New Jersey, generally practicing in New Jersey, regardless of age, past claim history, type of practice, experience or location, provided the insurance is approved by the State Committee on Medical Defense and Insurance. Coverage is continued unless it is felt (after prior discussion with the Medical Defense and Insurance Committee), that the doctor should not be renewed or should be cancelled. In other words, the decision to cancel or nonrenew is made after review by a group of about six of your fellow members or professional colleagues. It is not a decision arbitrarily made by a home office or field office of an insurance company.

Generally, local representation by an agent does not include service for claims, underwriting and counsel. However, the East Orange office of the American Mutual will handle all facets of this coverage including rating, underwriting, policywriting, billing (to be paid after policy is written and not with your application), claim investigation and case handling and payments. You truly have all phases localized in one office, with one man responsible for all activities and decisions. His interest is The Medical Society and its members and he is not departmentalized in his thinking as to a sales agent one day in giving coverage and the claim agent the next day in denying coverage. His thinking must be consistent to satisfy the company and The Medical Society. There will be a claim manager and claim department localized in the same office to handle only professional liability and professional premises liability problems. Members of the claim department will be specialists and not jacks of all trades in handling all types of claims. They will not be interested in nuisance settlements or the payment of $100 or so just to close a file.

Under the Loss Control Program, a county committee, composed of local doctors will review all the evidence together with the claim manager's recommendation and then decide if they recommend the case be settled or defended. *No claim will be settled without consent of the insured doctor.* Is there any other insurance company in New Jersey which has claim men spending 100 per cent of their time on doctors' problems exclusively? There certainly is none which would have a claim man-

ager or general agent to serve you, who will devote 100 per cent of his time to your problems only.

Think of this program as being that of The Medical Society of New Jersey. Decisions are made by The Medical Society with the aid and counsel of the insurance company's representative and legal counsel. Think of it this way and you will come closer to the real intent in back of the entire program.

J. A. BRITTON, MANAGER,
New Jersey Division
American Mutual Liability
Insurance Company

Hypnosis and the Doctor-Patient Relationship

Following is an abstract of the official position of the American Psychiatric Association on the subject of hypnosis. Its New Jersey District Branch concurs in this statement and asks its publication.

Hypnosis is appropriately and properly used in therapy only when it serves therapeutic goals without undue risks. With selected patients, it can be used for sedative, analgesic and anesthetic purposes; for the relief of apprehension and anxiety; and for symptom suppression. It can also be, on a more highly selective basis, an adjunct in the treatment of patients with neurotic or psychotic illness.

Hypnosis calls for all examinations necessary to a proper diagnosis. Induction of the trance is the least important of the many facets of the procedure and under no circumstances should it be taught independently.

Whoever makes use of hypnotic technics, therefore, should have sufficient knowledge of psychodynamics to avoid its use in clinical situations where it is contraindicated or even dangerous. Although similiar dangers attend the inept use of all aspects of the doctor-patient relationship, the nature of hypnosis renders its inappropriate use particularly hazardous. For hypnosis to be safe, even for the relief of pain or for sedation, a knowledge of the dynamics of human motivation is essential.

To be adequate for medical purposes, courses in hypnosis should be given in conjunction with medical institutions or teaching hospitals, under the auspices of the department of psychiatry and in collaboration with departments which are similarly interested. Although lectures, conferences and discussions are helpful, the basic learning experience must derive from supervised clinical contact with patients. Many physicians have enrolled in the inadequate brief courses taught often by individuals without medical training. These courses have concentrated on hypnotic-trance technics and have covered psychodynamics and psychopathology in a superficial or stereotyped fashion.

CONCLUSIONS

1. Isolated courses limited to the teaching of trance induction are strongly disapproved.
2. The teaching of hypnosis should take place in medical schools and other psychiatric training centers. When taught in such a climate, where students can acquire adequate knowledge of psychiatric principles, hypnosis may become a useful adjunct to therapy.
3. The teaching of hypnosis should be of sufficient duration and depth for students to acquire adequate understanding of its place in relation to other psychiatric treatment modalities; of its indications and contra-indications; of its values and its dangers. Decisions regard the depth and extent of the teaching of hypnosis should remain flexible, and should be made by the psychiatric departments teaching such courses.
4. An expansion of facilities for the teaching of hypnosis is needed particularly at the postgraduate level. Postgraduate courses in medical schools and other teaching centers under the direction of the department of psychiatry are recommended.
5. Physicians practicing hypnosis should do so only in their own fields of *medical* competence.
6. The need for continued study of hypnosis and for adequate research is emphasized, with particular reference to delineating its place in the total treatment program.

Obituaries • • •

DR. CHARLES A. BREITSTADT

Death came to one of Newark's veteran practitioners on February 17, with the passing that day of Charles A. Breitstadt, M.D. Born in Long Island in 1890, Dr. Breitstadt was graduated from Bellevue in 1914. An internship in New Jersey brought him to our state, and here he remained. A family doctor in the old tradition, Dr. Breitstadt was also interested in pediatrics and school medicine and served for many years as one of the physicians for the Newark Board of Education.

DR. MARTIN H. COLLIER

Death came on February 10 to Dr. Martin H. Collier, who for three decades was Superintendent and Medical Director of the Camden County Hospital. Dr. Collier was a 1911 graduate of the Jefferson Medical College. He became interested in chest disease work and was a governor of the American College of Chest Physicians. He had a term as president of the Camden County Medical Society and he was on the New Jersey State Board of Health at one time. He also served as president of the New Jersey Tuberculosis League and of the Camden Kiwanis Club.

A Fellow of the American College of Chest Physicians, Dr. Collier was also head of the Woodbury Council of the Knights of Columbus and an FACP.

Dr. Collier, who was born in 1885, was 76 years old at the time of his death.

DR. HARVEY M. EWING

One of the pioneer electrocardiologists of New Jersey died on March 15. Dr. Harvey M. Ewing, who was born in Pittsburgh in 1887, was a graduate of the Medical School of the University of Pennsylvania, Class of 1913. He was a Diplomate of the American Board of Internal Medicine, a governor of the New Jersey Heart Association, a Fellow of the American Heart Association, and past-president of the Associated Physicians of Montclair and Vicinity.

Dr. Ewing, for many years was Chief of Staff at the Mountainside Hospital. He was also at one time medical director of the Heart Unit at the Orange Hospital Center and was generally credited with having been the guiding spirit of that unit during its formative stages.

Dr. Ewing was an early worker in the field of cardiology among school children and was at one time director of the cardiac program for the Newark Public Schools. He was one of the first doctors in New Jersey to use and develop the electrocardiograph. He was a captain in the Medical Corps during World War I. Dr. Ewing was one of the first physicians in the United States to earn a sub-specialty diploma in cardiovascular diseases from the American Board of Internal Medicine. Dr. Ewing was the founder of the Victoria Foundation, the unit which concentrates on rheumatic heart disease in children.

DR. FRANK L. FOSTER

Dr. Frank L. Foster died on February 2 at his home in Cranford. Born in Lynchburg, Virginia, in 1895, Dr. Foster was graduated in 1921 from the University of Virginia Medical School. He came north to serve an internship at the Kings County Hospital in Brooklyn and then set up an office the following year in Cranford. At first he was a general practitioner, but became increasingly interested in radiology and eventually became a Diplomate of the American Board of Radiology. Dr. Foster was elected to the American College of Radiology in 1948 and was also a Fellow of the Academy of Medicine in New Jersey.

He was affiliated with the roentgenologic departments of the Elizabeth General Hospital and the Rahway Memorial Hospital. A veteran of World War I, he was active in American Legion affairs.

DR. ALBERT JAHN

Dr. Albert Jahn of Clifton died on March 3 after a brief illness. Born in Passaic in 1893, he was graduated in 1915 from the New York Medical College. After a general internship, he enlisted in the medical corps of the United States Army in 1917 and then, at the request of the British Army, was detailed for medical work with British troops until his return to the States in 1921. He became interested in roentgenology and became director of x-ray work at the Passaic General Hospital. Dr. Jahn was an early diplomate of the American Board of Radiology. He was affiliated with several hospitals in the Passaic County area and was active in the affairs of the Radiologic Society of North America.

DR. BENJAMIN MANN

One of Middlesex County's better known anesthesiologists, Dr. Benjamin Mann died suddenly on February 19. A native of New York City (where he was born in 1904) Dr. Mann received his M.D. degree in 1933 at the medical school of the University of St. Louis in Missouri. He came back east to serve an internship in the Newark City Hospital and settled in New Jersey. He became a general practitioner with special skill and training in anesthesiology, and served in that capacity at the Perth Amboy General Hospital where he was Associate Anesthesiologist. In 1942, Dr. Mann, then 38 years old, abandoned a busy practice to enter the Army, where he served in the medical corps throughout World War II. Dr. Mann also served several terms as senior physician for the Perth Amboy Board of Education.

DR. CHARLES RICH

After a long illness, Dr. Charles Rich of Newark and Essex Fells, died on St. Valentine's Day. Dr. Rich, born in 1892, was a native of and a life-long resident of Newark. He received his M.D. degree in 1915 at the medical school of the University of Vermont and interned at the Martland Medical Center in Newark. Then, in 1917, at the conclusion of his internship, he volunteered for service in the Army and went to France, working with combat troops, and later with the Army of Occupation. Mustered out in 1920, he returned to work and entered private practice. He was a family doctor in the early 1920s but became increasingly interested in surgical pathology and general surgery. He was on the Board of Governors of the Essex County Anatomical and Pathologic Society (serving a term as chairman of that Board) and was a Fellow of the American College of Surgeons. He also had served as president of the medical staff at Martland Medical Center where, for many years, he was an attending surgeon. He was surgical consultant to many hospitals in the Essex County area.

DR. EDWIN STEINER

A half-century of active medical and surgical practice came to a close on February 28 with the death that day of Edwin Steiner. Born in 1877, he was graduated in 1901 from the Jefferson Medical College. Until 1917 he did general practice and then served as a senior examiner for the Selective Service System in 1917 and 1918. He became increasingly interested in gynecologic surgery, eventually limiting his practice to that specialty. At one time he was coroner of Essex County. Dr. Steiner was on active duty as a senior officer in the Public Health Service during World War II. For many years he was treasurer of our Essex County Medical Society and he served a term as president of the Anatomical and Pathological Society. An F.A.C.S., he was, until his retirement from active service, chief of gynecology at the Newark Beth Israel and was on the surgical service of St. James and St. Barnabas Hospitals in Newark.

DR. ARTHUR WELLER

At the grand age of 91, Dr. Arthur Weller died on February 22. A 1903 graduate of the Hahnemann Medical College of Philadelphia, Dr. Weller moved to Essex County after his internship in 1904 and served the people of the Orange area for 50 years thereafter. At one time he was president of our State Board of Medical Examiners. A general practitioner, he was affiliated with both Mountainside and Orange Memorial Hospitals. Dr. Weller was for many decades active in the affairs of the Essex County Medical Society.

Announcements • • •

Symposium on Poisoning

On Wednesday, May 31, the State Department of Health will sponsor a symposium on accidental poisoning. A star-studded faculty will discuss artificial kidney, toxicologic aspects of chemical warfare, poison control centers, and the problem of prevention.

The full-day session at the Princeton Inn, Princeton, N. J., begins with registration at 9:30 a.m. There is no charge for registration. Luncheon reservations are arranged in advance. Address inquiries and luncheon reservations to:

New Jersey State Department of Health
21 E. State Street
Division of Preventable Diseases
Trenton, N. J.

Psycho-Pharmacology Lectures

The New Jersey State Hospital at Ancora, announces lectures in psycho-pharmacology to be held at Ancora on Tuesday evenings from 7:00 to 9:00 p.m. The lectures are given by Walter W. Baker, Ph.D., Associate Professor of Pharmacology at Jefferson Medical College. You are welcome to attend.

April 18—Pharmacology of the neuromuscular junction
April 25—Tranquilizing agents
May 2—Energizers
May 9—Central autonomic mechanisms and drug action
May 16—Neurochemical bases of the psychoses
May 23—Neuro-endocrine relationships
June 6—Drugs in hyperkinetic disorders
June 13—Pharmacologic approach to nausea and vomiting
June 20—Sedatives, hypnotics, and analgesics
June 27—The pharmacology of alcohol and addiction.

Cancer Colloquium in Newark

The distinguished British teratologist, Dr. Manuel Lederman, will speak in Newark on Saturday morning, April 29, under the joint auspices of the Newark (N. J.) Presbyterian Hospital and the New Jersey State Department of Health. The second speaker will be Charles Norris, M.D., of Temple University in Philadelphia. Their topic: Management of Cancer of the Larynx. The seminar starts at 10:00 a.m. at the Nurses' Home of the Presbyterian Hospital, 27 South Ninth Street in Newark. A two-hour program is scheduled.

Electro-Encephalographic Papers Available

Available to any member of this Society is a copy of the papers and discussion at the Colloquium on Electro-encephalography held in Princeton last fall. For your copy, write to Division of Chronic Illness, State Department of Health, Trenton 25, N. J.

Positions Available for GP's

General practitioners are acceptable for the Psychiatry and Neurology Service of the VA Hospital, East Orange. Waiver of age limit will be considered. GP's will be trained for the work. Salary depends largely on experience and qualifications. Communicate with Director, Professional Services, VA Hospital, East Orange.

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society* was held February 14 at Bergen Pines Hospital, Paramus.

Mrs. Harry E. Carman, President of the Woman's Auxiliary of the Bergen County Medical Society presented a check in the amount of $1,336.88 to the Medical Student Loan Fund. This sum was realized from a dinner dance and entertainment held by the Auxiliary in November. As she left she was accorded a standing ovation.

Membership certificates were presented to Dr. Felix J. Venutolo, Dr. John G. Bell, Jr., Dr. Alfred Del Vecchio and Dr. Richard P. Gilligan who were elected to Active membership at the last meeting.

The following Associate members elected at the last meeting were asked to rise to be introduced to the members present: Dr. Martha R. B. Adams, Dr. Claudio M. Castelli and Dr. Robert H. Glick.

The following were approved for election to membership: Active—Louis Reuling, Thomas F. Lenihan, Arnold M. Sobel, Max K. Griffel and Jaroslaw Rozankowski; Associate—Arnaldo N. Apolito, Barnett L. Elkin and Mary Elkin; Courtesy—Eugene Gersh, Howard E. Medinets and David M. Weeks; Emeritus—Sadie Blackman, A. Ivan Mader, Jr. and Aloysius F. Padden; Leave of Absence—Armin W. Docter and John P. Iandoli.

The Chair announced that the School and Child Health Committee of this Society had arranged a seminar on "A Team Approach to School Health Problems" to be held March 4, at the Garden State Auditorium.

Dr. R. Keating, Program Chairman, introduced Dr. John F. W. King to present the topic for discussion and the panel members. Dr. King announced that the topic for the evening was "Lung Cancer and Smoking" and introduced Dr. Daniel Horn, Associate Director of Statistical Research for the American Cancer Society.

Dr. Horn stated bluntly that: "In 1963, New Jersey will experience as many deaths from lung cancer as the whole country did in 1930." He enumerated studies on the relationship of smoking to lung cancer, pointing out that there are significantly more deaths among smokers than among non-smokers. He closed his presentation with the following: "Cigarette smoking is a direct contributor to the incidence of lung cancer and is as close to a medical fact as can be obtained without other studies requiring another 50 years to do."

Dr. King then presented Ernest L. Wynder, M.D., an associate of Sloan-Kettering Institute and Associate Professor on the Sloan-Kettering Division of Cornell Medical College. Dr. Wynder stressed the extreme rarity of lung cancer among non-smokers, and re-affirmed the evidence that smoking and lung cancer have a close relationship.

Dr. King introduced Oscar Auerbach, M.D., Consultant to Veterans Administration Hospitals in the New York region and to the U. S. Navy, Associate Professor of Pathology at New York University Medical College. Dr. Auerbach showed a series of slides giving microscopic evidence of lung cancer. Other slides illustrated the tremendous rise in the incidence of lung cancer in relation to the amount smoked.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

In spite of snow and ice-covered roads, an excellent attendance by physicians and attorneys marked the February 9 joint dinner meeting of the *Burlington County Medical Society* and Burlington County Bar Association. Held at the Cherry Hill Inn, the evening began with a social hour followed by a full-course capon dinner.

President Boudwin gave a welcoming address to our attorney guests, and introduced Dr. Jesse McCall, President of The Medical Society of New Jersey, and Mrs. McCall. Dr. McCall conveyed greetings from the State Society.

James M. Davis, Esq., President of the Burlington County Bar Association, greeted the members and introduced the Bar Association's distinguished guests: Burlington County Court Judge Thomas W. McGann, and Superior Court Judge Arthur W. Lewis.

Coordinating the evening's program were Robert Heal, M.D., program chairman of the Society, and John Dimon, Esq., for the Bar Association.

Speaker of the evening was Joseph W. Spelman, M.D., Medical Examiner of Philadelphia, who spoke of "The Role of a Medical Examiner in a Modern Community." Accompanied by interesting slides, Dr. Spelman's talk was a thought-provoking subject, well worth considerable thought by John Q. Citizen as well as the medical and legal professions.

Following the scientific presentation, the assembly disbanded and took the opportunity to renew acquaintances with some of their seldom-seen friends and associates.

EDWARD D. WILDMAN, M.D.

Reporter

Cumberland

The February meeting of the *Cumberland County Medical Society* was held at the Cumberland Hotel, Bridgeton, February 14 at 2:30 p.m., with the president, Alfred O. Davies, M.D., presiding. Twenty-nine members were present.

Carl N. Ware, M.D., of Shiloh, presently serving as Second Vice-President of The Medical Society of New Jersey, resigned as a member of the Nominating Committee and the House of Delegates of The Medical Society of New Jersey

Nicholas E. Marchione, M.D., of Vineland, was elected to fill the unexpired term of Dr. Ware. Posts of alternate member of the Nominating Committee, and Chairman of Delegates to The Medical Society of New Jersey have been filled by Sherman Garrison, Jr., M.D., of Bridgeton and Richard Kerdasha, M.D., of Vineland, respectively. Mario A. Pastore, M.D. of Vineland filled the vacancy of alternate delegate.

Thomas C. Donnelly and Vladimir Kohut of Vineland, were welcomed as Associate members to the Society.

James S. Knowles, M.D., of Millville is to receive the Golden Merit Award at the Annual Medical Society of New Jersey meeting next May.

The guest speaker, Stanley Dische, M.D., of London, Assistant Professor of Radiology, Jefferson Medical College, discussed, "Some Controversial Aspects of Radiation Therapy."

Dr. Dische stated that since the inception of radiation therapy some sixty years ago, there has been a 30 to 40 percentage of five-year survivals in special cases of far advanced cancer for which surgery offered little cure.

He illustrated his talks with slides showing a picture of the patient before and after radiation treatment. The results were astounding.

Furthermore, Dr. Dische explained the Cobalt machine unit which is used in radiation therapy. This unit, he cited, is easier to use than other high frequency units.

Following a question and answer period, dinner was served.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding, the regular meeting of the *Hudson County Medical Society* was held at the Jersey City Medical Center on February 7. Speaker of the evening was Dr. Louis Rousselot, Director of Surgery, St. Vincent's Hospital, New York City and Professor of Clinical Surgery at New York University Medical College. Dr. Rousselot's topic was "The Clinical Management of Portal Hypertension."

Dr. Benedict J. Duffy of Seton Hall College of Medicine and Dentistry was elected to regular Active membership at this meeting. Drs. Margaret M. Beke and Henry John Schwarz, Jr., were elected to Associate membership in the Society.

Following the business meeting, a collation was served.

LOUIS KOSMINSKY, M.D.

Reporter

Middlesex

Roosevelt Hospital was host to the *Middlesex County Medical Society* at its regular meeting February 15 at 9:00 p.m.

Dr. Stanley A. Gadek, president, read the Trustees' recommendation to reject the Relative Value Index. A vote of confidence was then given to the Board of Trustees on this matter. The Society voted unanimously to oppose the Relative Value Index.

A request for the County Society to buy television time to present our side of the story in answer to CBS television presentation of February 2nd of "Business of Health, Money and Politics," was rejected by the Society with the recommendation that the AMA buy the time and select a more capable speaker.

Dr. John Parente, Chief of the Gynecologic Cancer Service, Metropolitan Hospital, gave an encouraging paper on the clinical application of chemotherapy to gynecologic malignancies. He feels that good progress is being made and eventually biopsy cells can be cultivated and sensitivities to therapeutic agents tested to determine the most efficient one to use.

THOMAS I. STEINBERG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held January 17 at the St. Joseph Hospital in Paterson. The occasion was the Fifth Meyer Notkin Memorial Lecture, cosponsored by the Society and by the Passaic County Heart Association.

Dr. F. Albert Graeter, president of the Passaic County Medical Society, welcomed those attending, and conducted a brief business session. The following were elected to Associate membership: Edward Bradley of Paterson and Nina Drazniowsky of Teaneck.

Dr. Graeter read the following resolution which was adopted for presentation to the 1961 House of Delegates.

> Whereas, The polyvalent influenza vaccine has proved its efficacy and is the only defense against the epidemic disease, influenza, and
>
> Whereas, several public and semi-professional institutions and agencies are sending out directives urging immunization influenza, and
>
> Whereas, there is already a tendency on the part of public agencies to distribute free vaccine, and
>
> Whereas, the American Medical Association in the case of the anti-poliomyelitis campaign issued a directive to all the State medical societies and these in turn to their constituent county societies, and

Whereas, the anti-influenza campaign is primarily a medical problem and our medical organizations should take the initiative and give leadership, now therefore

Be It Resolved, that the Passaic County Medical Society, through its representatives, urge the State of New Jersey Medical Society, and through it the American Medical Association, to evaluate and give leadership to the anti-influenza campaign similar to the campaign against poliomyelitis.

The meeting was then turned over to Dr. Edward Wolfson, who called upon Dr. David Roth, Chairman of the Program Committee of the Passaic County Heart Association. Dr. Roth spoke highly of Dr. Meyer Notkin, not only for his outstanding work for the Heart Association and St. Joseph Hospital but also because he contributed so mightily to the elevation of cardiologic practice in this area. Dr. James Rogers then introduced the guest speaker, Israel Steinberg, M.D., Associate Professor of Clinical Radiology and Medicine at Cornell University Medical College. Dr. Steinberg spoke on "Clinical Evaluation of Intravenous Abdominal Aortography and Peripheral Arteriography."

At the conclusion of the scientific session, a collation was served by the St. Joseph Hospital.

IRVING CHRISMAN, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was called to order at 4:40 p.m. on Friday, February 17, 1961 by the president, Ford A. Spangler. There were 33 members and 3 guests present.

Dr. John Madara reported for the Legislative Committee, noting that there were several pieces of legislation pending. These include a bill by Senator Waddington requiring an applicant's signature agreeing to blood or breath tests in suspected drunken driving cases prior to issuance of a driver's license.

Following a discussion of the Relative Value Index by Dr. C. B. Norton, the members approved this program.

Dr. Spencer Davison, advisor to the Woman's Auxiliary, stated that he had met with the Executive Committee of the Auxiliary and that the Auxiliary would arrange for a second Nursing Scholarship. Future requests for approval of projects for the Auxiliary will be submitted to the county society in writing. Dr. Davison also noted that the members of the Auxiliary were interested in obtaining additional information regarding pending legislation and the procedures connected with introduction and passage of this legislation.

Guest speaker for the evening was Dr. William Dock, Professor of Medicine at the State University of New York. His topic was *Hypertension and Its Management*. Dr. Dock was sponsored by the Salem County Heart Association as a part of its Professional Educational Program.

The causes and effects of primary and secondary hypertension were outlined and discussed by Dr. Dock.

Dr. Dock also outlined many of the procedures which he uses in the diagnosis and treatment of hypertensive heart disease. Following his very informative and instructive discussion, a question and answer period was held reflecting the interest provoked at this meeting.

The members and guests adjourned to dinner at 6:30 p.m.

G. F. REICHWEIN, M.D.

Reporter

Book Reviews

The Split-Level Trap. Richard E. Gordon, M.D.; Katherine K. Gordon, R.N. and Max Gunther. New York 1961. Random House. Pp. 348. ($4.95)

That medicine is—and should be—a social science is becoming increasingly evident. Here is a book which details the sociologic factors in a variety of emotional and psychosomatic disorders. It is a careful, and scientifically validated study of the impact of suburban life on the physiology and psychology of human beings who live in this "split-level trap." The author points out how the pace and pressure of suburban life wreak their toll. The presentation is through case studies, recited in vivid language. Instead of preaching didactically, the authors make their points with case reports. Similarly in the therapeutic half of the book, they do not list pious generalities about what to do. They cite chapter and verse and show how the proposed technics have actually worked. There has been a lot of grumbling about suburban life in the past few decades. Here is a pioneer text in showing just how it produces its effects. The material is an enlargement and popularization of 15 papers by Dr. and Mrs. Gordon in several medical journals. It is to the credit of this periodical that five of the fifteen appeared in the JOURNAL of The Medical Society of New Jersey. The senior author is a member of our Bergen County Medical Society.

FELIX A. UCKO, M.D.

Occupational Diseases and Industrial Medicine. R. T. Johnstone, M.D. and S. E. Miller, M.D. Philadelphia 1960. Saunders. Pp. 482. Sixty illustrations. ($12.00)

Modern Occupational Medicine. Edited by A. J. Fleming, M.D. with 22 contributors. Philadelphia 1960. Lea and Febiger. Ed. 2. Pp. 587, with 67 illustrations. ($12.00)

General practitioners are now taking care of many industrial workers—particularly since factories have set up suburban and rural plants. As households become mechanized and as housewives use more complex detergents and electrical equipment, the problems of industrial medicine are invading the household. Thus, there is increasing need for more knowledge of industrial medicine by practitioners. These two books are welcome. They are of about the same size, equally well illustrated and retailing at the same price. The Fleming book is an anthology by 22 contributors, all from DuPont. The Johnstone-Miller volume has better material on occupational cancer and on lead poisoning, but has nothing on biostatistics. The Fleming book has an excellent chapter on statistics, and gives far more material on protective clothing and on medical plant surveys than can be found in the other text.

Psychiatric aspects of industrial medicine are neglected by Johnstone and Miller except for two pages on alcoholism. The book from DuPont has seven pages on alcoholism and 80 on other aspects of industrial psychiatry. It also has more exhaustive treatment of record keeping. Both books have up-to-date chapters on radiation and ionization hazards. The Johnstone book treats of the major industrial toxins chapter by chapter in a workmanlike fashion. The Fleming volume has better material on the role of the industrial nurse and on problems related to noise in industry.

The physician who has even casual contact with industry would do well to have one of these excellent books in his library.

HERBERT BOEHM, M.D.

Surgery as a Human Experience. J. L. Titchener, M.D. and Maurice Levine, M.D. New York, 1960. Oxford University Press. Pp. 285. ($6.00)

The authors are psychiatrists not surgeons. The book opens with a wise, witty and gracious convocation address by Dr. Levine that is worth the price of admission. The book's theme is that surgery is a human experience which the psychiatrist can explore and the surgeon should understand. The surgeon will be helped towards that goal by reading this book and falling into the habit of thinking that emotions can alter structure, just as alterations in structure produce emotional reactions. The psychosomatic concept is central here, and the authors present it with clarity and without special pleading. The text includes some practical suggestions on history taking, which, if followed, will give the surgeon a new dimension in anamnesis. There is a chapter on methods of psychologic treatment for surgical treatment and another one on presurgical preventive psychiatry. There will, I think, be other works in the next few years on this subject; but Titchener-Levine will long be recognized as the pioneer.

VICTOR HUBERMAN, M.D.

Chemotherapy in Emotional Disorders. By F. F. Flach, M.D. and Peter R. Regan, M.D. New York 1960. McGraw-Hill. Pp. 314. No illustrations. ($10.00)

Both psychologic and pharmacologic methods have a place in the treatment of emotional disorders. The authors of this volume spell out in detail how the various drugs may be used. They mention the importance of concomitant psychotherapy, but their instructions here are rather general. The volume cannot be considered a "how to do it" manual in psychotherapy. With respect to drugs and other somatic methods, the authors give exact dosages, indications and contraindications. They offer a handy table for converting trade names into generic names and *vice versa*. They give more space to barbiturates than one expects in a 1960 book. ("The most effective therapeutic agents for the reduction of anxiety" they say "are barbiturates and meprobamate.") Attention is given to the newer tranquilizers (right through to the 1960 summer issues), anticonvulsants, endocrines, steroids, energizers, and anti-parkinson drugs. Also discussed are electronic and psychosurgical methods.

It is their thesis that "there exists evidence to substantiate the claim that psychiatric illness is linked with physiologic disorders." They concede, however, that "psychologic factors may induce psychiatric illness" and hope to merge both approaches into a unified treatment program.

In addition to regimes for neuroses and psychoses, Flach and Regan also offer treatment for personality disorders. On the psychologic side they suggest "repeated emphasis on the results which come about when the patient fails to utilize rational thinking." The somatic approach is to use disulfiram in "certain patients" and anticonvulsants in personality disorders associated with electro-encephalogramic abnormalities.

Although the retail price of $10 may seem high for an unillustrated book of only 314 pages, it must be pointed out that this is a meaty monograph covering the whole spectrum of behavior-modifying drugs.

HENRY A. DAVIDSON, M.D.

Respiration. A translation of **Der Atmung.** (Rossier, Buhlmann, and Wiesinger) by P. C. Luchsinger, M.D. and K. M. Moser, M.D. St. Louis, 1960. Mosby. Pp. 505 with 95 illustrations. ($15.75)

A true understanding of respiratory physiology requires more mathematical grasp and more interest in physical and chemical theory than the average practitioner can be expected to have. Even its vocabulary may be a little difficult, as one reads of photo-electric oximetry or alveocapillary gradients. The subject is ably attacked in this readable translation of a second edition of a German classic. Attention is first paid to the physiology of respiration, including a careful study of the role of blood and respiratory gases. The spotlight then shifts to technics of investigation. This is followed by a clinical section: a treatise on pulmonary insufficiency and pulmonary hypertension with consideration of the spectrum of specific pulmonary diseases from atelectasis and asthma to thoracic deformities and tuberculosis.

The authors do not neglect nonpulmonary problems with respiratory facets—as, for example, the effort syndrome, or lung function in obesity, or renal acidosis. There is thoroughly up-to-date material on high altitude breathing and a brief but useful chapter on pulmonary function of the athlete. Nine pages of equations, and biochemical and biophysical tabulations are found in the appendix, which concludes with a bibliographic list of 2000 classified references. This definitive volume on the pathology and physiology of respiration, will, for a long time to come be the standard reference work in its field.

ULYSSES M. FRANK, M.D.

Fundamentals of Chest Roentgenology. By Benjamin Felson, M.D. Philadelphia, 1960. W. B. Saunders Co. Pp. 301, illus. ($10.00)

Roentgenology of the chest is regarded by the uninitiated, as one of the simple, more elementary forms of x-ray diagnosis. In this excellent, concise book, Dr. Felson quickly dispels such ideas. He points up the "building blocks" necessary for a logical evaluation and interpretation of the presenting roentgenogram. The value of the routine project is emphasized for detecting lesions. The less familiar and special views are then stressed with reference to their part in clarifying and differentiating those lesions whose nature remains obscure after detection. Emphasis is rightly placed on anatomy and physiology to explain how structural changes alter a given shadow or other abnormality. The text is divided into nine chapters (lobes, segments, pleura, hili, etc.), each dealing with the changes to which these portions fall heir. Numerous excellent roentgenographic reproductions supplement the text to illustrate the points.

With due attention to the radiation factor, the value of a quick, effective fluoroscopic study is described in orderly sequence. Equally important, its indications are noted. This valuable, ready reference is recommended not only for the roentgenologist but for all medical men who interpret chest fluoroscopy and roentgenography.

CARL KNITZER, M.D.

The 195th Annual Meeting
OF
The Medical Society of New Jersey
Saturday-Wednesday, May 13-17, 1961
HADDON HALL, ATLANTIC CITY

Daily Schedule

Friday, May 12, 1961

5:00 p.m.—Board of Trustees

Saturday, May 13, 1961

10:00 a.m.—Registration Opens

2:00 p.m.—House of Delegates

3:30 p.m.—Golden Merit Award Ceremony

4:00 p.m.—Open Discussion on Medical-Surgical Plan

6:00 p.m.—Board of Trustees' Dinner (by invitation only)

8:30 p.m.—Nominating Committee

Sunday, May 14, 1961

11:00 a.m.—Reference Committees

1:00 p.m.—Exhibits Open

2:00 p.m.—Motion Picture Theatre

2:30 p.m.—House of Delegates (election)

5:30 p.m.—Warren County Reception (by invitation only)

5:30 p.m.—Essex County Reception (by invitation only)

9:00 p.m.—Presidential Reception

10:00 p.m.—Music and Dancing

Monday, May 15, 1961

9:30 a.m.—House of Delegates

10:00 a.m.—Motion Picture Theatre

2:00 p.m.—Motion Picture Theatre

6:00 p.m.—"Dutch Treat" Cocktail Party

7:00 p.m.—Dinner-Dance

Tuesday, May 16, 1961

9:00 a.m.—Board of Trustees

9:30 a.m.—Scientific Sessions:
- Clinical Pathology
- General Practice and Neuropsychiatry
- Obstetrics and Gynecology
- Orthopedic Surgery and Rheumatism
- Radiology and Urology

10:00 a.m.—Motion Picture Theatre

12:30 p.m.—Luncheons:
- Section on General Practice, and New Jersey Chapter, American Academy of General Practice
- Section on Rheumatism
- Section on Surgery, and New Jersey Chapter, American College of Surgeons
- Radiological Society of New Jersey

2:00 p.m.—Motion Picture Theatre

2:00 p.m.—Scientific Session:
- Anesthesiology, Otolaryngology, and Surgery

5:00 p.m.—Hahnemann Medical College Alumni Cocktail Party (Alumni wives invited)

6:00 p.m.—Technical Exhibitors' Reception-Buffet

9:00 p.m.—Music and Dancing

Wednesday, May 17, 1961

9:30 a.m.—Scientific Sessions:
- Allergy and Chest Diseases
- Cardiovascular Diseases and Metabolism
- Dermatology and Pediatrics
- Gastroenterology and Proctology
- Medicine and Ophthalmology

10:00 a.m.—Motion Picture Theatre

12:30 p.m.—Luncheons:
- New Jersey Allergy Society
- New Jersey Chapter, Americal College of Chest Physicians
- Section on Dermatology

1:00 p.m.—Exhibits and Registration Close

Golden Merit Award Ceremony

Saturday Afternoon, May 13, 1961

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding
Jesse McCall, M.D., President

Master of Ceremonies
John F. Kustrup, M.D., Chairman, Council on Public Relations

Marshals
Presidents of component societies whose members are receiving awards.

Dinner-Dance

Monday Evening, May 15, 1961

7:00 p.m.

honoring

PRESIDENT AND MRS. JESSE McCALL

Toastmaster

Richard I. Nevin, Executive Officer, The Medical Society of New Jersey

Introductions

Mrs. Floyd D. Gindhart, President-Elect, Woman's Auxiliary

Ralph M. L. Buchanan, M.D., President-Elect

Official Guests

Presentation of Fellow's Key
To: Jesse McCall, M.D., President
By: F. Clyde Bowers, M.D., Immediate Past-President

Presentation of Fellowette's Pin
To: Mrs. Ralph K. Bush, President, Woman's Auxiliary
By: Jesse McCall, M.D., President

Entertainment
All Star Show

Music and Dancing

Motion Picture Theatre

Sunday Afternoon, May 14, 1961; Monday and Tuesday Mornings and Afternoons, May 15 and 16, 1961; and Wednesday Morning, May 17, 1961

10:00 a.m.

Anorectal and Sigmoidoscopic Examination with Differential Diagnosis

Malcolm R. Hill, M.D., School of Medicine, College of Medical Evangelists, Los Angeles, Calif.

This film emphasizes the importance of anorectal and colonic examination, its simplicity, and its technic

10:35 a.m.

Waiting People

New Jersey Rehabilitation Commission, Trenton

Demonstrates to the practicing physician the value of comprehensive rehabilitation to his patients of any disease category, and the part the Commission plays in this respect.

10:55 a.m.

External Cardiac Massage

James R. Jude, M.D.; W. B. Kouwenhover, Dr. Ing.; G. Guy Knickerbocker, M.S.E.; Johns Hopkins Medical Institutions

The film describes the recently developed technic whereby hearts that have stopped beating may be started again *without* opening the chest. An animation sequence illustrates how manual depression of the lower sternum compresses the heart, and forces blood into the pulmonary and systemic vessels. Release of pressure allows the chest to expand, and the heart to fill again. Combined with assisted ventilation, the technic (if begun within four minutes after cardiac arrest) assures the central nervous system of sufficient oxygen to prevent serious damage. The film shows the steps that may be taken to resuscitate patients whether the heart arrest occurs inside or outside the hospital. It distinguishes between heart arrest and ventricular fibrillation; illustrates the use of the external defibrillator as part of the resuscitation technic; features an interview with a successfully resuscitated patient whose heart had gone into ventricular fibrillation one year earlier; demonstrates the application of the technic to infants and children; and discusses the use of various drugs as adjuncts to external cardiac massage.

11:25 a.m.

The Mechanism and Control of Nausea and Vomiting

Produced by Smith Kline & French Laboratories, Philadelphia, Pa.

Using fluoroscopy and animation, the film reviews some of the disease states that cause vomiting, and illustrates the roles of the gastro-intestinal, respiratory and central nervous systems in vomiting. A description is given of the experimental evidence obtained during the past ten years for the separate functions of the vomiting center and the chemoreceptor trigger zone. The pharmacologic rationale for the control of vomiting with phenothiazine drugs is described, and the place of phenothiazine anti-emetic agents in conservative therapy is discussed. Side effects and their management are also explored.

2:00 p.m.

The Silent Witness

Produced for The Wm. S. Merrell Company, The American Bar Association, and the American Medical Association

This film deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court.

2:35 p.m.

Radiation: Physician and Patient

Produced in cooperation with the American College of Radiology, this illustrates the medical diagnostic radiologic examinations. It deals with the selection of patients and procedures for radiologic study in problems encountered by the general practitioner and in the specialties.

3:25 p.m.

Coccidioidomycosis

Marco Bruschi, M.D., Bakersfield, Calif.

These pictures cover the entire disease entity and place emphasis upon the dermatologic, roentgenographic, pathologic and laboratory aspects of coccidioidomycosis. Geographic, epidemiologic, medical and surgical phases are discussed.

Film program arranged and presented through the cooperation of Smith Kline & French Laboratories, Philadelphia, Pa.

Scientific Section Meetings

Tuesday Morning, May 16, 1961

CLINICAL PATHOLOGY

MILTON H. KANNERSTEIN, M.D., Chairman, Newark
HARRY H. STUMPF, M.D., Secretary, Montclair

9:30 a.m.

Symposium on Certain Aspects of the Cancer Problem

Genetics and Cancer

N. Conant Webb, Jr., M.D., Assistant Professor of Preventive Medicine, Seton Hall College of Medicine, Jersey City

Chromosome aberrations have been found in leukemia; the technics, their limitation, and the findings will be reviewed. It will be shown how some viruses interact with chromosomes. Evidence will be presented that mouse mammary cancer milk virus may be of this type. Other genetic aspects of neoplasia will be briefly reviewed.

Viruses and Carcinogenesis

Chester M. Southam, M.D., Chief of Clinical and Oncogenic Virology Section and Associate Member, Memorial Center for Cancer and Allied Diseases, New York, N. Y.

There is no proof of a viral cause of any human cancer, but there are numerous examples of virus-caused cancer of animals. There is no longer any obstacle to the theoretical possibility that virus may likewise play a role in the etiology of human cancer. Data supporting that statement will be presented. The concept of multiple factors operating simultaneously or sequentially to cause cancer will be discussed.

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

Symposium continued

Endocrine Treatment of Cancer

Bernard J. Koven, M.D., Assistant Professor of Medicine, Seton Hall College of Medicine, Jersey City

Endocrine therapy of cancer is defined as any artificially produced alteration in the endocrine environment designed to induce cessation of growth or regression of advanced cancer. Such alterations may be achieved by surgical ablative procedures such as castration in either sex, adrenalectomy, and hypophysectomy, or through the use of additive hormones such as the sex steroids and cortisone-like drugs. The major area of usefulness for endocrine therapy is in the treatment of disseminated cancers of the breast and prostate, and to a lesser extent, in the leukemias, Hodgkin's disease, lymphosarcoma, and in certain other settings in neoplastic disease.

Radiations and Carcinogenesis

John L. Tullis, M.D., Attending Pathologist, Overlook Hospital, Summit

That ionizing radiations are capable of producing cancers in exposed tissues became evident in 1902, just seven years after x-rays were discovered. Since that time considerable information has accumulated about the carcinogenic properties of ionizing radiations. In the adult, doses of one or more thousand rads and a latent period of several years are required for radiation carcinogenesis. In children, much smaller doses of radiation are capable of carcinogenesis. Ionizing radiations are of inestimable value in the diagnosis and treatment of many diseases. They should, however, be administered only by experts and then only where there is some clear indication for their use.

GENERAL PRACTICE AND NEUROPSYCHIATRY

Joint Meeting

General Practice

A. GUY CAMPO, M.D., Chairman, Westville
GEORGE C. PARELL, M.D., Secretary, Newark

Neuropsychiatry

WILLIAM E. GANSS, M.D., Chairman, Plainfield
IRA S. ROSS, M.D., Secretary, South Orange

9:30 a.m.

Role of the Physician in Prevention and Treatment of Emotional Disorders in Children

John B. Reinhart, M.D., Associate Professor of Pediatrics and Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

Psychiatric principles are adaptable to pediatric practice. Psychiatric illness follows the rules and patterns of "organic" illness. In psychosomatic disease, attention must be paid to both organic and emotional factors.

Children's symptoms are often a signal of family imbalance. Exploration of family attitudes can be rewarding without being too time-consuming.

Prevention of the common psychologic problems seen in pediatric practice is possible; for example: feeding, toilet training and sleep problems. Attention to the need for the child to separate himself from his parents and for them to permit such separation is important.

Physicians must learn not to expect too much of themselves nor to feel they "must do something." To listen is important and necessary to help people. The family physician can be a potent force in prevention and management of emotional disorders in children.

10:00 a.m.

The Recognition of Early Mental Aberration by the First Interview Technic (Illustrated by Recordings and Management)

Abraham M. Ornsteen, M.D., Emeritus Professor of Neurology, and Chairman of Neurological Department, The University of Pennsylvania School of Medicine, Philadelphia, Pa.

Emotional disturbance is a challenge to every practitioner. Most psychiatric work in the community can and should be done by physicians who are not psychiatrists. The basic emotional problem is almost always anxiety, a distress that usually stems from unharmonious relations among people. Definitive treatment must reduce anxiety by preventing or improving troubled relationships. This can be accomplished only with psychologic procedures, such as psychotherapy. Physiologic methods may relieve certain symptoms of mental disease. Psychologic methods attack the core of the illness: anxiety. Remedial psychotherapy consists of establishing a strong physician-patient relationship, followed by re-education. It replaces unhealthy attitudes with healthy ones, activates favorable potentialities and strengthens character.

10:35 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:05 a.m.

Office Management of Psychiatric Problems by the General Practitioner and Pediatrician

Moderator

Joseph C. Borrus, M.D., Attending in Neuropsychiatry, St. Peter's General Hospital, New Brunswick

Panelists

Abraham M. Ornsteen, M.D., Philadelphia, Pa.
Ralph Brancale, M.D., Medical Director, Diagnostic Center, Menlo Park
Robert E. Verdon, M.D., Cliffside Park
A. Guy Campo, M.D., Westville; General Practice Staff, West Jersey Hospital and Our Lady of Lourdes Hospital, Camden

Emphasis will be placed on those areas in psychiatry most often encountered by the general practitioner and pediatrician. Special topics will include: (1) School, disciplinary and retardation problems; (2) Early recognition of emotional disorder and avoidance of neurotic tendencies; (3) Convulsive disorders; (4) Enuresis; and (5) Preparation of patient and family for psychiatric referral.

Early recognition of depressions and alcoholism, will be discussed with recommendations as to brief psychotherapeutic procedures, tranquilizers and energizers most efficacious for each condition.

Finally, suggestions and "rules of thumb," will be offered for more intensive psychiatric, pharmacologic, physiologic and hospital therapies when indicated.

12:30 p.m.

Luncheon—Section on General Practice, and New Jersey Chapter of American Academy of General Practice

Reservations: George C. Parell, M.D.

329 S. Orange Ave., Newark

OBSTETRICS AND GYNECOLOGY

William H. Ainslie, M.D., Chairman, Metuchen
Douglas W. Payne, M.D., Secretary, Asbury Park

9:30 a.m.

Anesthesia in Obstetrics

Frank L. Paret, M.D., Co-Director, Division of Obstetrics and Gynecology; and Chairman, Department of Obstetrics, Middlesex General Hospital, New Brunswick

Discussor: Raymond E. Jacobus, M.D., Asbury Park

The availability of general anesthesia for vaginal delivery is a maternal contribution to the safety of mother and baby. To enhance the effectiveness of general anesthesia, the obstetrician should administer sedatives and analgesics during labor. The

practitioner needs some basic knowledge of the drugs and anesthetic agents—their indications, contra-indications, technics of use and hazard. It is the aim of this presentation to offer such basic knowledge.

10:00 a.m.

Pediatric Gynecology

Hammell P. Shipps, M.D., Senior Attending Gynecologist, Cooper Hospital, Camden

Discussor: Edward G. Waters, M.D., Jersey City

Gynecologic problems in children will, on occasion, be faced by nearly every practicing physician. Management of these problems falls particularly within the domain of the pediatrician and the gynecologist. Conditions affecting the genitalia of the female child range from the more frequently occurring inflammatory process, through anomalies and endocrine disturbances, to the less common neoplasia. This paper presents its subject from the clinical point of view.

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

Some Factors Affecting the Fetal Heart Rate

Louis M. Hellman, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, State University of New York, Down State Medical Center College of Medicine, Brooklyn, N. Y.

Discussor: Harry F. Hutchinson, M.D., Neptune

An instantaneous fetal heart rate meter has been developed which uses a phonocardiograph and a unique method of maintaining the signal for a long duration of time. With this it is possible to test the effect of various stimuli on the fetal heart rate of normal gravidas. To date, the effect of 100 per cent oxygen, 12 per cent oxygen, atropine, epinephrine, and tobacco have been tested. Some of these stimuli produce marked effects on the fetal heart rate with definitely measurable parameters. These are reproducible in normal persons and may delineate normal from abnormal fetal development. It is hoped to test the effects of these stimuli in individuals suffering from toxemia and diabetes where fetal survival may be jeopardized. It may even be possible to test fetal well-being *in utero* by means of the type of response elicited.

ORTHOPEDIC SURGERY AND RHEUMATISM

Joint Meeting

Orthopedic Surgery

ARTHUR S. THURM, M.D., Chairman, Trenton
JAMES F. COLLIER, M.D., Secretary, Haddonfield

Rheumatism

JACOB HEYMAN, M.D., Chairman, Newark
JOHN J. CALABRO, M.D., Secretary, Jersey City

9:30 a.m.

Whiplash Injuries of the Cervical Spine

Daniel B. Eck, M.D., East Orange: Assistant Attending in Orthopedic Surgery, Orange Memorial Hospital, Orange

The mechanism and treatment of this increasingly common injury will be discussed in the light of more recent observations, newer x-ray technics, and medical and legal implications.

9:55 a.m.

Orthopedic Management of Marie Strumpell Disease

Bertram M. Kummel, M.D., Morristown

Emphasis is on the utilization of all modes of treatment; the orthopedic approach is just one part. Conservative orthopedic measures include bed rest, traction, physical therapy (especially exercise), bracing and intermittent traction.

Surgical methods include lumbar osteotomy, procedures relative to the involvement of the hip joint and resection for sterno-clavicular or acromio-clavicular involvement.

10:20 a.m.

Intermission—Election of Officers and Visit to Exhibits

10:50 a.m.

Medical Considerations in Marie Strumpell Disease

Carlo Nosenzo, M.D., Instructor in Medicine, Seton Hall College of Medicine, Jersey City

Co-Author: John J. Calabro, M.D., Jersey City

Rheumatoid spondylitis begins in young adult life starting with pain and stiffness in the low back. Gradually over the years it may involve the

entire spine, eventually producing severe disability if not taken care of. Medical treatment consists of salicylates and phenylbutazone for relief of pain, and intensive physical therapy, such as heat, exercises and cervical traction. With patience and a program geared at long-range management, remarkably good results can be achieved. In this disorder males outnumber females ten to one.

11:15 a.m.

Twelve Years of Steroid Studies in the Treatment of Rheumatic Diseases

Charles H. Slocumb, M.D., Consultant in Rheumatic Diseases, Mayo Clinic and Mayo Foundation, Rochester, Minn.

The study of adrenal steroid administration in rheumatic diseases centers around the study of (1) induced (exogenous) Cushing's syndrome with its dangers, and (2) the effect of steroids on the course of diseases, both the suppressive beneficial effect, and the unfavorable effect which steroids may eventually have in some patients.

Special reference is made to the place of (1) large dose, short term; (2) large dose, long term; (3) small dose, long term; and (4) local effect of steroid injections.

12:30 p.m.

Luncheon—Section on Rheumatism

Reservations: John J. Calabro, M.D.
Seton Hall College of Medicine, Jersey City

RADIOLOGY AND UROLOGY

Joint Meeting

Radiology

John J. Thompson, M.D., Secretary, Asbury Park
Nathan S. Deutsch, M.D., Secretary, Plainfield

Urology

Edward A. Brady, Jr., M.D., Chairman, New Brunswick
John C. Clark, M.D., Secretary, Asbury Park

9:30 a.m.

Cinefluorographic Studies of the Urinary Tract Structure and Function in Man

John A. Benjamin, M.D., Clinical Associate Professor of Urology and Surgery, The University of Rochester School of Medicine, Rochester, N. Y.

Cinefluorography or x-ray movies provide a valuable method of studying urologic problems, particularly, from the dynamic and functional point of view. Conditions will be presented which demonstrate the usefulness of x-ray movies as a method of urologic study and diagnosis. Among the subjects to be considered are vesico-ureteral reflux, bladder neck obstruction, post-prostatectomy control of urination, stress incontinence, and some unusual diagnostic problems.

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

The Differential Diagnoses of Renal Cysts and Tumors

John C. Clark, M.D., Asbury Park: Attending Urologist, Fitkin Memorial Hospital, Neptune

This paper offers a comprehensive evaluation of the diagnostic procedures necessary to differentiate between renal cysts and tumors. The author has had personal experience in the clinical and roentgenologic differentiation of renal cysts and tumors.

11:30 a.m.

Percutaneous Transfemoral Renal Arteriography and Nephrotomography

Mordecai Halpern, M.D., Assistant Professor of Radiology, The New York Hospital-Cornell Medical Center, New York, N. Y.

The percutaneous transfemoral catheter technic of renal arteriography is a safe and precise radiologic method for demonstration of the anatomic-pathologic condition of the renal arteries. Its most important application is in the study of renal hypertension in that it provides selective visualization of the surgically remediable lesions of occlusive renal artery disease.

The roentgenologic technic of nephrotomography is of inestimable value in the study of renal mass lesions. Urologists and radiologists should have a greater understanding of its simplicity of performance and its high degree of diagnostic accuracy. It enables the patient to have a completely pre-operative study.

12:30 p.m.

Luncheon—Radiological Society of New Jersey
Reservations: Jules H. Bromberg, M.D.
89 Lincoln Park, Newark

ANESTHESIOLOGY, OTOLARYNGOLOGY AND SURGERY

Joint Meeting

Anesthesiology

ROBERT K. EGGE, M.D., Chairman, Maplewood
EDWARD G. BOURNS, M.D., Secretary, Westfield

Otolaryngology

MYRON J. SHAPIRO, M.D., Chairman, Irvington
ARTHUR DINTENFASS, M.D., Secretary, Atlantic City

Surgery

EUGENE L. WATKINS, M.D., Chairman, Morristown
WAYNE W. HALL, M.D., Secretary, Paterson

Luncheon—Section on Surgery, and New Jersey Chapter of American College of Surgeons
Reservations: Eugene L. Watkins, M.D.
2 Franklin Place, Morristown

2:00 p.m.

Symposium on Anesthesia for Tonsillectomy and Adenoidectomy

Moderator

Robert K. Egge, M.D., Chairman, Section on Anesthesiology, Maplewood

Insufflation Technic for T and A

Hector A. Quesada, M.D., Pleasantville; Associate Anesthesiologist, Atlantic City Hospital, Atlantic City

The maintenance of anesthesia by insufflation of anesthetic vapors is a controversial question. The technics, advantages, disadvantages, indications and contra-indications are discussed. The disadvantages are that airway is hard to maintain and that the air-ether mixture is explosive. Since there is no "bag," it is difficult to control respirations. Some teams object to the dissemination of ether vapor throughout the room. Patients often develop laryngospasm from the irritating ether vapors. On the other hand, the method does provide good carbon dioxide eliminations and it may be used for operations about the head, face and neck when endotracheal anesthesia is not feasible. Other advantages of insufflations are the simplicity of equipment and the ease with which the method can be learned.

The Advantages of Endotracheal Tubes for T and A

Joseph F. Lutz, M.D., Livingston; Assistant Attending in Anesthesia, Orange Memorial Hospital, Orange

Endotracheal anesthesia during tonsillectomy and adenoidectomy offer a guaranteed airway and a method of maintaining an adequate exchange of respiratory gases. The newer non-explosive agents can cause a rapid obtunding of laryngo-tracheal sensations and a rapid awakening postoperatively. Their dosage can best be controlled *via* an endotracheal tube. Because of the usual brevity of the operative procedure and lack of trauma during placement of a clean tube of correct size, this method means few if any complications.

Rectal Thiopental for Tonsil Induction

Joseph S. Berman, M.D., West Orange; Adjunct, Department of Anesthesia, Newark Beth Israel Hospital, Newark

Pre-operative apprehension in children can be safely eliminated by rectal thiopental hypnosis. Result is a more nearly normal physiology during surgery and the immediate postoperative period. Sodium thiopental in 10 percent solution is used in precise dosage of 10 to 15 milligrams per pound of body weight. This results in basal narcosis but not anesthesia. Anesthesia is achieved by the use of ether, vinyl ether, or other volatile anesthetic agent. Consensus from both parents and children is complete acceptance of this procedure because of its amnesia of the "roughest" part of the hospital stay.

Control of Bleeding in T and A

Myron J. Shapiro, M.D., Irvington; Associate in Otolaryngology, Newark Beth Israel Hospital, Newark

History of bleeding, low hemoglobin and unresolved respiratory infection are three preventable factors influencing operative bleeding. The merit of drugs is questionable. Careful surgical technic with ligation of major bleeding points is important. Stress is placed on early recognition of postoperative bleeding, and its immediate control by positive means. The surgeon must assess the degree of blood loss, and maintain adequate fluid and food intake during the postoperative period. Late bleeding is usually associated with superficial infection which should be treated. In all cases, general anesthesia is hazardous because the stomach is full of blood.

Guest Panelist

Benjamin H. Shuster, M.D., Professor of Otolaryngology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Question and Answer Period

3:15 p.m.

Intermission—Election of Officers and Visit to Exhibits

Tuesday Afternoon, May 16, 1961

3:45 p.m.

Diagnosis and Treatment of Head and Neck Cancer with Emphasis on the Significance of a "Lump" in the Neck

Robert W. Tilney, Jr., M.D., General Surgical Staff, The Morristown Memorial Hospital, Morristown

Discussors: Anesthesiologist—George T. Henderson, M.D., Bound Brook; Otolaryngologist—Edgar P. Cardwell, M.D., Newark

This is a discussion of the diagnosis and treatment of head and neck cancer illustrated with diagrams, colored slides and a short silent colored movie. Emphasis is placed on the proper handling of a "lump" in the neck. A summary will be offered of cases done at Morristown Memorial Hospital. This will show that this type of surgery is feasible in a community hospital.

Wednesday Morning, May 17, 1961

ALLERGY AND CHEST DISEASES

Joint Meeting

Allergy

Aaron Weiner, M.D., Chairman, Fair Lawn
Frank H. Feldman, M.D., Secretary, Newark

Chest Diseases

Saul Lieb, M.D., Chairman, Newark
Thomas C. DeCecio, M.D., Secretary, Cliffside Park

9:30 a.m.

Symposium on Air Pollution

Air Pollution—Meteorology and the Allergic Patient

Frank L. Rosen, M.D., Maplewood; Chairman, Meteorology Section, American College of Allergists

Air pollution, a major peril to all of us, is a far greater threat to the allergic patient. Various air pollution incidents are reported with resultant respiratory illnesses, especially bronchial asthma, in Elizabeth, Linden, Yokohama, Weirton, Brisbane, San Paolo, Belgium, London and Donora. Questions to be raised include: (1) What do we know about air pollution? (2) What can we now do about the problem? (3) What can we do in the future?

Medical Aspects of Air Pollution

George A. Paul, M.D., Irvington; Chairman, Air Pollution Control Committee, Hospital and Health Council, Newark

Air pollution is the result of the use of fossil fuels, industrialization and urbanization. Under certain meteorologic, geographic and industrial conditions, acute episodes of heavy air contamination occur causing illness and death. Three of these episodes are briefly described. Chronic illness is unfavorably influenced by contaminated air. The physician, with his knowledge of the health aspects, should cooperate with the engineer, meteorologist and other scientists in seeking a solution to this problem.

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

Symposium continued

Air Pollution and Cancer Hazards

Wilhelm C. Hueper, M.D., Chief, Environmental Cancer Section, National Cancer Institute, Bethesda, Md.

The marked irregularity of the lung cancer mortality rates, of their progression rates and of their sex distribution rates in different countries, different regions and different metropolitan areas of the same country militate strongly against a predominant causal action of a single factor such as cigarette smoking. A critical evaluation of the total epidemiologic, medical, and experimental evidence favors the view that carcinogenic chemicals in industrial effluents and automobile exhaust as well as recognized occupational respiratory carcinogens have played an important role in bringing about the marked increase of lung cancers in countries of the Western world during the past 50 years.

The Allergic Aspects of Air Pollution—Pulmonary Pathology

Paul Gross, M.D., Research Pathologist, Industrial Hygiene Foundation, Mellon Institute, Pittsburgh, Pa.

Three categories of target tissues may be involved in pulmonary hypersensitivity reactions:

bronchial passages, the respiratory membrane and the vessels. Only the first two are known to be affected by air pollutants.

The particle-size of the pollutant determines the target tissue and hence the nature of the disease, in susceptible individuals. Smaller particulates (2 micra or less in size) impinge largely on the alveolar surface and thereby produce a chronic interstitial pneumonitis. Larger antigen-containing particles (more than one micron in size) impinge on the tracheobronchial mucosa, and thereby produce asthma. Illustrations are presented illuminating these facts.

12:30 p.m.

Luncheons—New Jersey Allergy Society
Reservations: Frank H. Feldman, M.D.
115 Lyons Ave., Newark

New Jersey Chapter, American College of Chest Physicians
Reservations: Saul Lieb, M.D.
804 Clinton Ave., Newark

CARDIOVASCULAR DISEASES AND METABOLISM

Joint Meeting

Cardiovascular Diseases

N. Maurice Re, M.D., Chairman, Palisade
Joseph M. Stein, M.D., Secretary, Camden

Metabolism

Robert H. Areson, M.D., Chairman, Upper Montclair
John F. Hiner, M.D., Secretary, Titusville

9:30 a.m.

Symposium on Intravenous Arteriography

Radiology

Joseph V. Cusmano, M.D., Attending in Radiology, Englewood Hospital Association, Englewood

Intravenous arteriography, widely used at the Englewood Hospital, has been found to be a safe and reliable diagnostic procedure. It affords excellent visualization of the thoracic and abdominal aorta, which permits vivid demonstration of aneurysms and occlusive disease.

With improved technic, excellent demonstration of the renal arteries has been obtained with demonstration of renal artery stenosis. Postoperative study of renal artery and aortic prosthetic devices is easily accomplished. The iliac and femoral arteries can also be demonstrated for study of occlusive disease. The method eliminates the need for direct puncture technics in most instances, and is being studied also as a definitive procedure for the evaluation of the renal arteries.

Joseph J. Gallagher, M.D., Attending in Radiology, Englewood Hospital Association, Englewood

Basically, the technic of intravenous aortography is the same as the Steinberg-Robb angiocardiographic procedure with some important modifications. A larger amount of contrast is used (up to 80 cubic centimeters of 90 per cent sodium diatrizoate). The larger amount of contrast in one arm gives as good a demonstration of the vessels as a double arm simultaneous injection of 50 cubic centimeters each. By using the Sanchez-Perez rapid cassette changer, and by varying its position in respect to the patient, the aorta, renal, iliac and femoral arteries are readily demonstrated.

Surgery

George O. Halstead, M.D., Cresskill; Attending in Surgery, Englewood Hospital Association, Englewood

Edward M. Miller, M.D., Attending in Surgery, Englewood Hospital Association, Englewood

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

Medical Management of Peripheral Vascular Disease

Walter Redisch, M.D., Associate Professor of Medicine, New York University Medical Center, New York, N. Y.

Recent years have brought two major advances in the approach to disturbances in peripheral circulation: (1) attempts to correlate the functional status of regional blood flow with structural changes in the vascular system and (2) technical possibilities of restoring primary regional circulation in occluded peripheral arteries. The close relationship of most cases of occlusive arterial disease of the limbs to atherosclerosis and related metabolic disorders is pointed out. The proportion of cases *not* suited for restorative surgery is high. Medical management based on physiologic principles is discussed. The use of anticoagulant drugs and of fibrinolytic agents in various parts of the vascular tree is considered.

11:30 a.m.

The Adrenal Cortex, Hypertension, and Congestive Failure

Herbert S. Kupperman, M.D., Associate Professor of Medicine, New York University Medical Center, New York, N. Y.

Co-Author: Richard L. Fogel, M.D., New York, N. Y.

The role of the adrenal cortex in regulation of electrolyte metabolism makes it a vital factor in the management of abnormalities of the cardiovascular system. The electrolyte-controlling hormone, aldosterone, plays an essential role in maintaining the homeostasis of the body with respect to volemia and water, sodium and potassium metabolism. In so doing, aldosterone may adversely or beneficially affect the cardiovascular system. The glucocorticoids, on the other hand, appear to be antagonistic to aldosterone as far as sodium retention is concerned and may actually be important in securing a definite diuretic effect where resistance to diuretics was developed. The balance of power between these two steroids is important in controlling the cardiac output and efficiency in the human. The hypertensive effects of aldosterone may cause the heart to fail. This is a factor to be considered in some patients with congestive heart failure. The role of the adrenocortical steroids in hypertension and congestive heart failure will be discussed, and therapeutic approach emphasized.

DERMATOLOGY AND PEDIATRICS

Joint Meeting

Dermatology

Benjamin B. Burrill, Jr., M.D., Chairman, Montclair
Sol J. Fanburg, M.D., Secretary, Newark

Pediatrics

Samuel C. Southard, M.D., Chairman, Ventnor
Milton Prystowsky, M.D., Secretary, Belleville

9:30 a.m.

The Unusual Skin Manifestations of the Pediatric Infectious Exanthems

Saul Krugman, M.D., Professor and Chairman, Department of Pediatrics, New York University School of Medicine, New York, N. Y.

Question and Answer Period

This presentation will review and illustrate unusual skin manifestations associated with a variety of infectious diseases. The interesting Kodachromes® were obtained from patients observed in this country and in Nigeria.

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

Management of Some Common Pediatric Dermatologic Problems

H. Harris Perlman, M.D., Clinical Professor of Pediatrics and Pediatric Dermatology, Jefferson Medical College of Philadelphia, Philadelphia, Pa.

Question and Answer Period

Management of infantile dermatoses requires understanding of common histo-pathologic disturbances and of pharmaco-dynamics. In his effort to normalize the skin (most quickly), the practitioner will be well advised to observe the principles of conservatism and simplicity, avoiding any untoward reaction. The prescription should be cosmetically acceptable and economically modest.

The speaker has chosen seven common dermatoses for which (with the aid of slides) he will discuss the rationale of topical agents and their indications for optimum effect. Sheets that may serve as a therapeutic guide (for the remedies discussed) will be distributed.

11:50 a.m.

A New Approach to the Therapy of Psoriasis

Sol. J. Fanburg, M.D., Newark; Attending Dermatologist, Clara Maass Memorial Hospital, Belleville

This is a report of the results obtained in a series of cases of psoriasis by the use of dextrorotatory lactic acid. The preparations were used internally and externally and the results observed over several months.

12:30 p.m.

Luncheon—Section on Dermatology

Reservations: Benjamin B. Burrill, M.D.

70 Park St., Montclair

GASTROENTEROLOGY AND PROCTOLOGY

SAMUEL M. GILBERT, M.D., Chairman, Newark
URBAN R. FINNERTY, M.D., Secretary, Montclair

9:30 a.m.

Office Management of Common Proctologic Lesions

Urban R. Finnerty, M.D., Director of Proctology, St. Vincent's Hospital, Montclair

Good office proctology depends upon thorough familiarity with the proctoscope and sigmoidoscope, careful general examination of the patient who seems to have only a rectal complaint, and recognition of the limitations of office treatment. In the management of fistula in ano, the extent of the tract should be discovered during an unhurried office examination, as a prelude to surgical treatment in the hospital.

10:00 a.m.

Intermission—Election of Officers and Visit to Exhibits

10:30 a.m.

Symposium on Liver Diseases

Moderator

Samuel M. Gilbert, M.D., Chairman, Section on Gastroenterology and Proctology, Newark

The Classification and Differential Diagnosis of Jaundice

Henry J. Tumen, M.D., Professor of Medicine, and Chairman of the Department of Medicine, The Graduate Hospital, Philadelphia, Pa.

Treatment of Hepatitis

Edwin M. Cohn, M.D., Associate in Gastroenterology, The Graduate Hospital, Philadelphia, Pa.

As part of the discussion of the treatment of hepatitis, the author will touch on the prevention of hepatitis. The presentation of active treatment will deal with the programs of rest and diet. Supplemental vitamin therapy will be mentioned. The place of steroid therapy in the management of hepatitis will be presented with a review of indications and contra-indications. The role of antibiotics in hepatitis will be reviewed. Special attention will be paid to the management of the acute fulminant form of hepatitis.

Management of Portal Hypertension

Benjamin H. Sullivan, M.D., Assistant Professor of Gastroenterology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Hemorrhage from esophageal varices is a major cause of death in patients with cirrhosis and portal hypertension. Portacaval shunts reduce the incidence and severity of hemorrhage but do not necessarily prolong life.

A study was made of 95 cirrhotic patients treated with portosystemic venous shunts. Survival data will be presented.

MEDICINE AND OPHTHALMOLOGY

Joint Meeting

Medicine

WILLIAM D. KIMLER, M.D., Chairman, Haddon Hgts.
WILLIAM J. SNAPE, M.D., Secretary, Camden

Ophthalmology

LOUIS A. AMDUR, M.D., Chairman, Jersey City
HENRY ABRAMS, M.D., Secretary, Princeton

9:30 a.m.

Validity of Radiation Protection Standards—Re-Evaluation of the Radium Dial Painters

Radium Research Project, New Jersey State Department of Health

Hyman W. Fisher, M.D., Project Physician, Livingston

Co-Authors: Carye-Belle Henle, M.D., Newark; Robert Bonda, D.D.S., Trenton; and Lester A. Barrer, M.S., Trenton

The radiation protection standard for radium is the only one based directly on human experience. This radium standard (upon which all others depend) was established 20 years ago as the result of a study of a small group of people with body burdens of radium. This paper is a preliminary report of our efforts to find and study several hundred additional former radium dial painters who are still alive 30 to 45 years after their exposure. This will enable us to determine long-range effects of varying body burdens of radium on man, and thus to assess the adequacy of current protection standards.

Wednesday Morning, May 17, 1961

10:00 a.m.

Effects of Radiation on the Eye

George R. Merriam, Jr., M.D., Assistant Professor of Ophthalmology, Institute of Ophthalmology, Columbia-Presbyterian Medical Center, New York, N. Y.

In radiotherapy of lesions of the head and neck region, the eye will frequently receive measurable amounts of direct or scattered radiation. Every effort should be made to minimize its exposure. The effects of various qualities of ionizing radiation on the ocular tissues will be discussed. The lens is the most radiosensitive structure. Recent studies on cataractogenic doses and time-dose relationships will be described. Measurements have been made on the amounts of radiation reaching the lens from the usual diagnostic x-ray procedures, including dental films, and this work will be discussed.

10:30 a.m.

Intermission—Election of Officers and Visit to Exhibits

11:00 a.m.

Clinical Experience with Malignant Lymphoma

Milton Shoshkes, M.D., Assistant in Medicine, Tumor Clinic, Newark Beth Israel Hospital, Newark

Co-Authors: Louis J. Levinson, M.D., Newark; Bertram Levinstone, M.D., Newark; and Bertram D. Hurowitz, M.D., Union

A group of 168 cases of malignant lymphoma treated at the Newark Beth Israel Hospital Tumor Clinic from 1930 to 1959 were tabulated and analyzed. Included were 84 cases of Hodgkin's disease, 54 of lymphosarcoma, 22 of giant follicular lymphoblastoma and 8 reticulum cell sarcoma. Average survival was 34 months for Hodgkin's disease, 27 months for reticulum cell sarcoma, 27 months for lymphosarcoma and 55 months for giant follicular lymphoblastoma.

Radiation therapy is still the mainstay in the control of malignant lymphoma and repeated courses were required in the majority of patients. Nitrogen mustard chemotherapy and adrenal corticosteroids, though helpful in controlling symptoms, have not increased the survival time in this group of patients as compared to other series reported prior to the use of this medication.

11:20 a.m.

Ocular Manifestations of Thyroid Disease

Alfonse A. Cinotti, M.D., Attending Ophthalmologist, Jersey City Medical Center, Jersey City

The ocular complications of thyroid disease are among the greatest difficulties encountered in the condition today. The resultant exophthalmos in addition to changing the general appearance of the patient can be disturbing to functioning of the eyes and may even produce serious visual disabilities. All too often surgery or medical treatment of the thyroid gland will relieve the systemic symptoms but ocular complications may remain or develop at a later date. Fortunately these complications are generally self limited. The present treatment is empirical which, when effective, works by reducing the pathologic effects rather than removing the cause.

11:40 a.m.

Hereditable Tumors of the Gastro-Intestinal Tract

John J. Calabro, M.D., Assistant Professor of Medicine, Seton Hall College of Medicine, Jersey City

Within recent years, there have been many papers on hereditary multiple polyposis of the gastro-intestinal tract. A proposed classification would include: (1) Multiple hereditary polyposis limited to the colon; (2) The Peutz-Jeghers syndrome (pigmentation-polyposis syndrome); (3) Multiple polyposis of the colon associated with soft tissue tumors and osteomata (Gardner's syndrome); and (4) Isolated polyps of the colon.

Separation of these syndromes is important, as is recognition, because of the difference in the clinical manifestations of each and in the type and extent of surgical correction.

12:00 noon

Question and Answer Period

House of Delegates

President, Jesse McCall, M.D., Newton

Secretary, Marcus H. Greifinger, M.D., Newark

Parliamentarian, Robert M. Backes, Trenton

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

SESSIONS

Saturday Afternoon, May 13, 1961

2:00 p.m.—First Session:

Call to Order

Invocation

Reverend L. Rodney Boaz, First Presbyterian Church, Newton

Organization of the House

Transactions of 1960 Annual Meeting

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Resolutions

Proposed Amendments to the Constitution and Bylaws

New Business

Announcements

Sunday Afternoon, May 14, 1961

2:30 p.m.—Second Session:

Report of Nominating Committee

Election

Monday Morning, May 15, 1961

9:30 a.m.— Third Session:

Reports of Reference Committees

Unfinished Business

Installation of Incoming President

Inaugural Address

Adjournment

Reference Committees

Sunday Morning, May 14, 1961

11:00 a.m.

Reference Committee "A"

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Officer

Reference Committee "B"

Reports of the:

- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Reports of the:

- Medical Service Administration of New Jersey
- Medical-Surgical Plan of New Jersey

Reference Committee "D"

Reports of the:

- Committee on Medical Education
- Committee on Physicians Placement Service
- Committee on Retirement Plan for Physcians
- Committee on Medical Defense and Insurance

Reference Committee "E"

Reports of the:

- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:

- Council on Medical Services and its Special Committees on:
  - Industrial Health
  - Workmen's Compensation

Reference Committee "G"

Reports of the:

- Council on Public Health and its Special Committees on:
  - Cancer Control
  - Child Health
  - Chronically Ill and the Aging
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation

Reference Committee "H"

Reports of the:

- Special Committee on Disaster Medical Services
- Special Committee on Traffic Safety
- Committee on Annual Meeting and its Subcommittees on:
  - Scientific Exhibit
  - Scientific Program
- Advisory Committee to Woman's Auxiliary
- Committee on Honorary Membership

Nominations for Emeritus Membership

Reference Committee on Constitution and Bylaws

Report of the:

- Committee on Revision of Constitution and Bylaws

Amendments to the Constitution
Amendments to the Bylaws

54th Annual Meeting
Woman's Auxiliary
to The Medical Society of New Jersey

CHALFONTE-HADDON HALL, ATLANTIC CITY

May 13 - 16, 1961

Mrs. Samuel L. Kaman, Chairman

Mrs. Anthony G. Merendino, Mrs. John F. Perez, Co-Chairmen

Daily Schedule

Saturday, May 13, 1961

10:00 a.m.—Registration Opens

Tickets on sale for:

Monday—Annual Luncheon
Tuesday—Inaugural Luncheon
Monday Evening—Dinner-Dance

1:00 p.m.—Coffee served until 3:00 p.m., Hospitality Lounge

3:30 p.m.—Golden Merit Award Ceremony

Sunday, May 14, 1961

9:00 a.m.—Registration

Tickets on sale for:

Monday—Annual Luncheon
Tuesday—Inaugural Luncheon
Monday Evening—Dinner-Dance

12:30 p.m.—Pre-Convention Executive Board Meeting

2:00 p.m.—Coffee served until 4:00 p.m., Hospitality Lounge

Featuring Art Exhibt

7:00 p.m.—Fellowettes' Dinner (by invitation)

9:00 p.m.—Medical Society Presidential Reception

Monday, May 15, 1961

8:30 a.m.—Registration

Continental Breakfast served until 9:15 a.m., Hospitality Lounge

9:00 a.m.—Tickets on sale for:

Monday—Annual Luncheon
Tuesday—Inaugural Luncheon
Monday Evening—Dinner-Dance

9:15 a.m.—General Session

12:30 p.m.—Annual Luncheon and Fashion Show

2:30 p.m.—General Session (reconvenes)

6:00 p.m.—Dutch-Treat Cocktail Party

7:00 p.m.—Dinner-Dance

Tuesday, May 16, 1961

9:00 a.m.—Registration

Tickets on sale for:

Tuesday—Inaugural Luncheon

9:00 a.m.—Coffee served until 11:00 a.m. Hospitality Lounge

10:00 a.m.—Post-Convention Board Meeting

11:00 a.m.—Reorganization Meeting

12:30 p.m.—Registration Closes
Inaugural Luncheon

6:00 p.m.—Reception and Buffet-Dinner for Exhibitors

9:00 p.m.—Cabaret (Dutch Treat, Bar and Dancing)

Scientific Exhibits

Exhibit Hours: 1:00 p.m. - 5:00 p.m., Sunday, May 14, 1961
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 15 and 16, 1961
9:00 a.m. - 1:00 p.m., Wednesday, May 17, 1961

Booth S-201. Cancer of the Colon and Rectum—Harry E. Bacon, M.D., Robert A. McGregor, M.D., Teodoro P. Nuguid, M.D., John T. McCormick, M.D., Cristopher Speers, M.D., and Douglas M. MacLean, M.D., Department of Proctology, Temple University Medical Center, Philadelphia, Pa.

The exhibit is based on personal experience in 2,000 cases with particular reference to the "pull-through" operation with sphincter muscle preservation. The display shows results of the operative management in the treatment of cancer of the colon and rectum with particular reference to the procedure of abdominoperineal proctosigmoidectomy "pull-through" with preservation of the sphincter muscles and no abdominal colostomy. Good results are obtained with proper selection of operation and properly used technic.

Booth S-202. The Role of Vagotomy in the Surgical Control of Duodenal Ulcer—Walter A. D'Alonzo, M.D., and James A. Lehman, M.D., St. Joseph's Hospital, and Women's Medical College of Pennsylvania, Philadelphia, Pa.

Presented here are the anatomy and physiology of the vagus nerve in relation to duodenal ulcer. Four hundred cases are reviewed. Results are graphically displayed.

Booth S-203. Transeptal Hypophysectomy—F. Robert Haase, M.D., and Julio T. Noguera, M.D., Asbury Park

This exhibit will show the relative simplicity of the transeptal approach to the hypophysis and the value of the procedure in refractory cases of metastatic carcinoma of the breast. The exhibit consists of posters reflecting indications for the procedure, pre-operative work-up, the technic and case histories. It is the conclusion of the exhibitors that transeptal hypophysectomy is a most useful procedure in the treatment of patients made invalid by metastatic carcinoma of the breast.

Booth S-204. A Simple Method for Continuous Recording of the EKG During Surgery—Peter Carbone, M.D., John Reilly, M.D., and William Treanor, M.D., All Souls Hospital, Morristown

Here is a simple, convenient, and inexpensive method of taking a continuous electrocardiogram during surgery. The exhibit shows an operating room table with built in attachments for the standard electrocardiographic leads and shows the use of specially designed small electrodes which may be affixed to the patient in the standard positions with tape and avoid interference with surgery. By means of this apparatus it is possible to have a continuous monitoring of the electrocardiogram during surgery.

Booth S-205. The Practical Management of Chest Injuries—Robert G. Trout, M.D., Julio C. Davila, M.D., and Robert P. Glover, M.D., Fitzgerald-Mercy Hospital, Darby, Pa.; and Presbyterian Hospital, Philadelphia, Pa.

This exhibit is designed primarily for the personnel who are first to see thoracic injuries. It presents in simplified fashion the types of injury sustained which need attention, the diagnostic criteria for these injuries, a review of the basic principles of anatomy and physiology of respiration and, in step-wise and outline form, the simple and direct methods of treatment that can be used by any physician in any locality without special equipment. Indications for skeletal immobilization, tracheostomy, thoracic intubation and other easily performed therapeutic measures and the simplified technics employed will be presented and graphically demonstrated by the use of a manikin.

Booth S-206. Allergic Rhinitis, A Common Cause of Epistaxis in Children—Leonard S. Girsh, M.D., Philadelphia, Pa.

This exhibit graphically illustrates allergic rhinitis as a common cause of nosebleed in children. The display renders visible the mechanism and incidence of this symptom. The "allergic salute" is a known source of nasal trauma. Allergic rhinitis as a common cause of recurrent epistaxis has not been fully appreciated. The exhibit shows the frequency of recurrent epistaxis in allergic rhinitis; the incidence of nasal trauma of the "allergic salute"; and the anatomic proximity of the highly vascular Kiesselbach's anterior nasal septal area.

Encouraging therapeutic results have been obtained with allergy care, local application of steroid ointment, plus the prevention of local trauma.

Booth S-207. Diagnosis and Treatment of Deafness Due to Otosclerosis—Julio T. Noguera, M.D., and F. Robert Haase, M.D., Asbury Park

This exhibit is focused primarily on the needs of the general practitioner. It demonstrates simple hearing tests that can be performed by the family doctor. Such tests will help him advise his patient intelligently. Also shown by illustrations,

drawings, specimens and an actual operating microscope, are the newer types of surgery available for the relief of deafness in otosclerosis, which is the major cause of deafness in young adults.

Booth S-208. Hearing Loss in Children With Middle Ear Pathology—Joseph Sataloff, M.D., and Seymour Wagner, M.D., Jefferson Medical College of Philadelphia, and Jefferson Medical College Hospital, Philadelphia, Pa.

About three out of every one hundred children have significant hearing losses. The most common symptoms are inattention and behavior problems. These hearing losses are often due to middle ear pathology and are correctable. Hearing losses can be detected and diagnosed in office practice with a tuning fork and audiometer. The most common causes are hypertrophied adenoids, secretory otitis media, acute and chronic otitis media and defects in the ossicular chain. The exhibit demonstrates several types of middle ear pathology and points out the practical measures available to family doctors and pediatricians for the diagnosis and correction of the difficulties. Simple methods of using tuning forks and performing myringotomies on models and cadaver ears are demonstrated and are made available for practice. New otologic advances are shown, including closing perforated eardrums, grafting new eardrums, repairing ossicular defects with a new bone glue (Ostamer®) and using the operating microscope, particularly for congenitally fixed stapes. Charts, pictures, models, and practical demonstrations are utilized.

Booth S-209. Diagnosis and Treatment of Deafness—David Myers, M.D., Woodrow D. Schlosser, M.D., Lindsay L. Pratt, M.D., and Richard A. Winchester, Ph.D., Temple University Medical Center, Philadelphia, Pa.

This otologic microsurgery exhibit presents the dramatic advances made during the past five years in the diagnosis and treatment of conductive or middle-ear deafness. Color photographs, slide transparencies, diagrams and charts illustrate the most modern and advanced procedures for identifying and treating surgically the deafness due to otosclerosis and chronic otitis media. The exhibit is of interest to the non-otologist as well as to the specialist in ear disease. Statistical summaries of long range experience with the technics presented are used to indicate the effectiveness of the surgical methods considered.

Booth S-210. Peak Hearing Levels in Health and Disease—Ralph A. Hall, M.D., Westfield

Has your hi-fi quotient been measured? Never before has this realm of human physiology been explored. Peak hearing levels are of value in health and disease. See the electronic equipment. Hear the audio-frequency generators. This investigation has posed some interesting questions and provided some valuable answers. Modern equipment has opened the way for more comprehensive study. Description of the work will be mailed to interested persons.

Booth S-211. Diabetes Screening in the Hospital, Physician's Office, and Community—Arthur Krosnick, M.D., and Gabriel Pickar, M.D., Middlesex General Hospital, New Brunswick; and New Jersey State Department of Health, Trenton

This exhibit consists of laboratory demonstration of technics and equipment for diabetes case-finding. Both blood and urine methods are covered. It documents the exhibition of practical methods of case-finding in the hospital, physician's office and community.

The results of existing case-finding programs are reviewed. Physicians attending this exhibit will be offered a postprandial blood sugar screening test without charge. Brochures will be distributed to visitors to the exhibit.

Booth S-212. Demethylchlortetracycline (DMCT) —A New Broad Spectrum Antibiotic—Chemistry, Pharmacology, and Clinical Experience—William M. Sweeney, M.D., Stanton M. Hardy, M.D., James M. Ruegsegger, M.D., Albert C. Dornbush, M.S., Jerry R. D. McCormick, Ph.D., and Newell O. Sjolander, Ph.D., Pearl River, N. Y.

This exhibit makes a comparison of the chemical structures of various tetracyclines. It reviews bacterial sensitivity testing for DMCT by both tube dilution and agar plate methods; and it shows human pharmacologic studies. Also summarized are the clinical responses following DMCT therapy of more than 7,000 patients suffering from a wide variety of infection.

Booth S-213. New Trends in Community Blood Banking—Bergen Community Blood Bank, Paramus

Shown here are visual items, pictures, and brochures, which present streamlined blood plans for families and individuals through a new cooperative blood program. The exhibit also shows how industries may participate in a county-wide program for blood.

Booth S-214. New Jersey Component of the American Society of Clinical Hypnosis—Bertha P. Rodger, M.D., Ridgewood

This exhibit acquaints the medical profession of the objective of this Society: to bring together professional people using hypnosis, to set up standards for training, to cooperate with all scientific disciplines in professional and public relationships in regard to the use of hypnosis and to stimulate research and publication in the field. The exhibit displays the uses of hypnosis in medical practice and makes available information regarding research in the field and present training programs.

Booth S-215. The Erythromycins—Newer Concepts—Richard S. Griffith, M.D., Marion County General Hospital, Indianapolis, Ind.

Antibacterial activity in the serum following ingestion of the lauryl sulfate salt of propionyl erythromycin is as rapid in onset and is as pro-

longed as that obtained with propionyl erythromycin when both are given fasting. Values following administration of the propionyl erythromycin lauryl sulfate with meals are similar to those when fasting. There is a falling off of antibacterial activity when the propionyl erythromycin was given to the subjects with their meals.

The antibacterial activity in the serum of subjects taking propionyl erythromycin lauryl sulfate is identical to the activity obtained with propionyl erythromycin when both are taken "on an empty stomach." It is shown that the propionyl erythromycin ester is not acid stable and produces lower antibacterial concentrations in the serum when taken with food than when fasting.

Propionyl erythromycin lauryl sulfate achieves as great antibacterial activity in the serum when taken with food as when fasting. The lauryl sulfate salt is acid stable and is not susceptible to the destructive action of gastric juice.

Booth S-216. Interstitial Fibrosis of the Lung in Rheumatic Heart Disease—Sylvan E. Moolten, M.D., Mikio Makino, M.D., and A. Marshall Smith, M.D., Middlesex General Hospital, New Brunswick

Low-grade chronic interstitial pneumonitis may determine much of the disability of rheumatic heart disease as a pulmonary syndrome or as a cause of right heart failure (cor pulmonale). Acute exacerbations may masquerade as "pulmonary edema" because of loud moist rales, wheezing, severe dyspnea, and cyanosis. Death may occur in circulatory collapse, especially after morphine, diuretics, and phlebotomy. Right heart failure, which occurs in many cases, is often intractable. Necropsy reveals massive right heart hypertrophy. A large component of the interstitial pulmonary fibrosis is possibly residual to recurrent attacks of rheumatic pneumonia, and not necessarily dependent on back pressure of blood from an obstructed mitral valve. The lesion occurs in severe form with mitral stenosis but may be associated with other types of valvular deformity, and even minimal valvular disease, supporting the concept that it is a primary component of the rheumatic complex, which, like other "collagen disorders," may involve the mesanchyme of the lung.

Booth S-217. Hypocholesterolemic Agents—A Comparative Study—Philip Lisan, M.D., Wilbur Oaks, M.D., Murray Miller, M.D., and John Moyer, M.D., Hahnemann Medical College of Philadelphia, Philadelphia, Pa.

Presented here is a comparative study of various agents for lowering serum cholesterol. The exhibit opens with the pro's and con's of the relationship of cholesterol to atherosclerosis. Results obtained with drugs that prevent absorption of cholesterol from the intestinal tract are presented. Also discussed are inhibitors of endogenous cholesterol synthesis (triparanol, and nicotinic acid) as well as agents that increase metabolism or excretion of cholesterol (d-thyroxine). Inhibitors of cholesterol synthesis are the most effective agents and least toxic. Combination therapy shows great promise in refractory cases.

Booth S-218. Manifestations of Muscular Dystrophy—Ade T. Milhorat, M.D., Muscular Dystrophy Associations of America, Inc., New York, N. Y.

This exhibit consists of three panels. The first is a set of color transparencies with appropriate descriptions showing the manifestations of muscular dystrophy. The genetics of the condition are graphically reviewed. The next panel shows postural changes and characteristics of various stages of progressive muscular dystrophy. The third panel presents color transparencies of personnel engaged in activity involved in various MDAA-sponsored research projects under the grants-in-aid program. The dystrophic mouse, now extensively used for this research, is shown and described. The hereditary aspects of the condition are explained. The Institute for Muscle Disease (an MDAA-sponsored project now under construction) is pictorially and functionally described. An automatic playback tape features an informational interview with a physician.

Booth S-219. Newer Aspects of Long-Term Therapy of Gouty Arthritis—L. Maxwell Lockie, M.D., Bernard M. Norcross, M.D., Salvatore LaTona, M.D., and Harold Robins, M.D., University of Buffalo School of Medicine, Buffalo, N. Y.

This exhibit shows the successful management of gouty arthritis with the newer long-term therapy. Diagnosis and adequate treatment of patients with complete control of their hyperuricemia is demonstrated through x-rays, photographs, and case histories. An effective treatment of more than ten years of uninterrupted therapy which has maintained the patients symptom-free and capable of living a normal life will be demonstrated in various charts. Patients who have been greatly incapacitated have been returned to a normal work schedule. Misconceptions which have led to inadequate therapy in many patients will be pointed out.

Booth S-220. Protein Electrophoresis—Abnormal Patterns and Components—Asher Yaguda, M.D., and Lewis Rifield, B.A., Martland Medical Center, and I.L.G.W.U. Health Center, Newark

This exhibit displays principles involved in electrophoresis; it shows characteristic normal and abnormal patterns seen in various disease states. It demonstrates cases seen by the exhibitors which demonstrate macroglobulinemia of Waldenstrom. Cryoglobulins and para proteins associated with myelomas and reactive reticuloses are also reviewed.

Booth S-221. Seek and Ye Shall Find—New Jersey State Department of Health, Trenton, cooperating with the U. S. Public Health Service

The aim of this exhibit is to stimulate surveillance for infectious syphilis. The display contains

color transparencies showing atypical lesions of early syphilis. This should be revealing to physicians who feel that they never see primary and secondary syphilis. The great upsurges in infectious syphilis since 1955 are vividly illustrated.

Booth S-222. Raynaud's Disease, Raynaud's Phenomenon, and Serotonin—Alfred Halpern, Ph.D., Herbert E. Shaftel, M.D., Norman O. Shaftel, M.D., and Paul H. Kuhn, M.D., Angiology Research Foundation, Great Neck, N. Y.

Raynaud's disease has been subject to more contradictory and conflicting reports than any other vascular disease. This exhibit describes the pathophysiology of this disease with particular emphasis on its etiology. The role of serotonin in propagating the cold stressor effects on the peripheral vascular system was studied in both normal subjects and patients with Raynaud's disease. It is pointed up by means of charts, drawings, photographs, and thermometric tracings. Results indicate that serotonin plays an important mediating role in Raynaud's disease. The findings may resolve the points of difference arising in the past.

Booth S-223. Exfoliative Cytology in the Diagnosis of Bronchogenic Carcinoma—J. Randolph Johnson, M.D., Olga Sonin, and Felix Traugott, Berthold S. Pollack Hospital for Chest Diseases, Jersey City

The standard by which all other staining methods have been compared has been the Papanicolaou technic. A recent innovation in exfoliative cytology has been fluorescent microscopy. Advantages of this method are: (1) its simplicity, and (2) the brilliant staining of malignant cells, thereby facilitating quick scanning. This exhibit offers a summary of the results obtained in the study of exfoliated cells in sputum and bronchial secretions by both methods (Papanicolaou and fluorescence technics) and their correlation with concomitant histologic studies. A review of the methods of sample collection, staining, and classification of cytologic findings is also presented.

Booth S-224. Arthritic Feet—John J. Calabro, M.D., Carlo J. Nosenzo, M.D., and Felix Traugott, Seton Hall College of Medicine, and Jersey City Medical Center, Jersey City

Shown here will be characteristic clinical and radiologic features of the feet in rheumatoid arthritis, psoriatic arthropathy, chronic tophaceous gout, degenerative joint disease and neuropathic joint disease. The demonstration includes wax moulages and photographs of radiologic findings.

Booth S-225. Traumatic Arthritis—Harold Lefkoe, M.D., Camden, American College of Legal Medicine

The phrase "traumatic arthritis" is often used, sometimes misused. This exhibit will clarify the term and emphasize its practical, medico-legal aspects.

Booth S-226. Profound Hypothermia in Cardiovascular Surgery—John Y. Templeton, III, M.D., and Ralph Lev, M.D., Jefferson Medical College Hospital, Philadelphia, Pa.; and St. Peter's General Hospital, New Brunswick

The basic principles and physiologic concepts of profound hypothermia are outlined relative to its use in cardiovascular surgery. Indications for and clinical examples of the use of this medium are presented. The profound hypothermia apparatus and technic of application for cardiac bypass and cardiovascular surgery with complete cardiopulmonary arrest will be demonstrated.

Booth S-227. Cineangiocardiography—John W. Marquis, M.D., John H. Donnelly, M.D., E. Johnson, M.D., Robert Pocelinko, M.D., J. Mathias, M.D., Peter P. Poulos, M.D., and Arthur Bernstein, M.D., Heart Institute, United Hospitals of Newark, Newark

This is a demonstration of technics and results in selective cineangiocardiography. It highlights the value of this procedure in conjunction with right and left heart catheterization.

Booth S-228. Open Correction of Mitral Stenosis and Insufficiency—Theodore R. Keith, M.D., Dryden P. Morse, M.D., Michael Ramundo, M.D., Pasquale Racaniello, M.D., Daniel Downing, M.D., F. Albert Graeter, M.D., William Cantwell, M.D., Nathan Nussbaum, M.D., and Lawrence E. Batlan, M.D., Passaic General Hospital, Passaic

Modern technics of diagnosis of mitral stenosis and insufficiency will be shown by means of left heart catheterization and ventriculography. Surgical treatment of combined mitral stenosis and insufficiency under direct vision with extracorporeal circulation and hypothermia will be displayed. Six panels show the diagnosis of mitral stenosis and insufficiency with stethophones and oscilloscope on which the heart sounds are visually displayed. Diagnosis by x-rays and ventriculograms will be demonstrated on x-ray boxes. In another panel a short motion picture will show the surgical correction of mitral stenosis and insufficiency by open technic. The final panel will give results. It will be made clear that the open technic for the treatment of mitral valvular disease has an ever-widening scope of application. Results of the open heart correction of mitral lesions have been encouraging when compared with the formidable medical prognosis.

Booth S-229. Use of Halothane in Obstetrics—Gene L. D'Alessandro, M.D., Presbyterian Unit, United Hospitals of Newark, Newark

A study is displayed comparing halothane with the more usual agents for obstetrical anesthesia. In over 500 halothane administrations, there was a decided advantage in the use of this agent. Postoperative complications and undesirable side effect

are at a minimum. In experienced hands, halothane is an excellent anesthetic agent for use in obstetrics.

Booth S-230. Treatment of Threatened Abortion—Herschel S. Murphy, M.D., Roselle; Floyd D. Gindhart, M.D., Trenton; and Ernest C. Lowenstein, M.D., Rahway

The exhibit consists of panels setting forth an outline of the study and treatment of threatened abortion. Data are presented outlining previous pregnancies with complications. Facts relating to successful termination of pregnancy at term with our treatment program are given. This regime includes hormone therapy, vitamins, minerals, diet and proper rest, together with psychotherapy.

Booth S-231. Simplified Postpartum Analgesia—David N. Danforth, M.D., and Fernando S. Santiago, M.D., Northwestern University Medical School, Chicago, Ill.; and Evanston Hospital, Evanston, Ill.

The exhibit presents and discusses one important phase of postpartum care, Analgesic agents are freely used to overcome the discomfort of episiotomy wounds and uterine involution. Formerly, narcotic preparations were the only available analgesics to accomplish this purpose. This entailed a narcotic license, the need to maintain records not required with medications which are not subject to the Harrison Narcotic Act, and strict security measures. These requisites imposed added burdens on the physician, nursing staff, and the hospital. The presentation here offered consists of a double-blind study comparing a conventional opiate and a non-narcotic agent. Data cover clinical observation of both agents in 400 cases. Emphasis is placed on the marked simplification for physician, nurse, and hospital by substituting an effective non-narcotic analgesic for an opiate in the postpartum period.

Booth S-232. Meprobamate in Premenstrual Tension—Medical and Social Aspects—Veronica Pennington, M.D., Veterans Administration Hospital, Jackson, Miss.

Premenstrual tension is presented as a social as well as a medical problem. This problem is often ignored both by patient and physician. The unrealized high incidence of premenstrual tension (confirmed in surveys by the author totaling 1500 subjects) and the importance of the syndrome as a factor in industrial absenteeism, marital difficulties, and crime, are emphasized. The multiple factors, both somatic and psychogenic, involved in etiology are explored. Methods of treatment are discussed. Details are presented outlining the treatment of more than 70 patients, with emphasis on psychogenic aspects.

Booth S-233. A Comprehensive Community Accident Prevention Campaign—William J. Farley, M.D., Nutley; and Samuel C. Southard, M.D., Ventnor; New Jersey Chapter, American Academy of Pediatrics

The exhibit emphasizes the tragic need for further activities directed towards the reduction of the tremendous numbers of accidents in childhood. The practicing physician can play a major role in reducing childhood accidents by initiating a community campaign. An example of such a program developed in Nutley is outlined. Also included in the exhibit are a series of simple and practical steps to assist and encourage the physician in planning a campaign in his community.

Booth S-234. Rectal Bleeding in Children—Richard C. Reed, M.D., and Anita Falla, M.D., Department of Pediatric Surgery, Babies' Hospital, Newark

Rectal bleeding is common in children. The exhibit presents a practical program of diagnosis based on experience in a pediatric center. Special attention is given to illustration of technics of diagnosis, including endoscopy and x-ray studies. Final results are compared with similar data from other pediatric institutions.

Booth S-235. Extracted Pertussis Antigen—A New Approach to an Old Problem—Carl Weihl, M.D., Cincinnati, Ohio; Harris Riley, Jr., M.D., Oklahoma City, Okla.; and Joseph Lapin, M.D., New York, N. Y.

A series of three-dimensional graphs are shown denoting problems associated with whooping cough. Included is a report of the results of a compartive study of whole cell pertussis antigen and a new antigenic extract of the H. pertussis organism. A comparison of reaction rates and antibody data is presented, together with a discussion of the role of antibody in prevention of the disease. It is shown that the extracted pertussis antigen produces significantly greater antibody response with significantly less systemic reaction than does conventional pertussis antigen.

Booth S-236. Treatment of Constipation in Infants and Children—Emanuel Dubrow, M.D., Beekman Downtown Hospital, New York, N. Y.

Complaint of delay or difficulty in defecation is frequent in pediatric practice. In addition to the establishment of regular routine correction of dietary errors and reduction of family tensions, many cases require laxative therapy. Characteristics of the more commonly used types of laxatives are described particularly as to their mode of action. Satisfactory results are presented in the treatment of functional and spastic constipation and that associated with emotional disturbances.

Booth S-237. Angioma in Bone—Daniel Wilner, M.D., Atlantic City; and Robert S. Sherman, M.D., Memorial Center for Cancer and Allied Diseases, New York, N. Y.

The exhibit reviews benign angiomatous tumors in bone. There were 45 cases of primary hemangio-

ma in bone. Of these, 27 (or 60 per cent) were found in the spine and skull and 18 were seen in the facial bones, ribs, clavicle, long bones, and foot. In the spine the "corduroy cloth" appearance prevails. In the skull one sees the characteristic "honeycomb" appearance. In the flat bones the "sunburst" pattern was observed with fairly good regularity. A "soapbubble" pattern was noted in other skeletal sites. There were 23 additional cases of soft tissue hemangioma. In 15 of these the bone was involved in some form or another. Some consideration was given to massive osetolysis or vanishing bone and its angiomatous relationship.

Booth S-238. Intravenous Arteriography—Robert Alan Keisman, M.D., Hunter S. Neal, M.D., and Melvin M. Meyers, M.D., Lankenau Hospital, Philadelphia, Pa.

Intravenous arteriography was developed by Steinberg, Evans, and Finby at the New York Hospital in 1959. A high concentration of radio-opaque material is introduced into the venous circulation by rapid injection simultaneously into both antecubital veins. The radio-opaque material passes through the right heart, the lungs, the left heart, and then the aorta. The x-ray films are exposed as the radio-opaque material traverses the artery being studied. Excellent arteriograms are produced of the entire length of the aorta, the common carotids, the cervical portion of the internal and external carotids, the cervical portion of the vertebrals, the subclavians, iliac, femoral, and popliteal arteries. This study is useful in the study of patients with strokes to rule out obstruction of the cervical portion of the carotids and vertebrals. It is valuable in aortic aneurysm, hypertension to rule out renal artery stenosis. This method is helpful in arteriosclerotic obstruction to the iliac, femoral or popliteal arteries and in many other lesions of the major arteries. Intravenous arteriography is a simple procedure that can be done with standard x-ray equipment. It is relatively safe and the discomfort to the patient is slight. All arteries that can be approached by present surgical methods can be adequately visualized by intravenous arteriography.

Booth S-239. A Method of Treatment for Breast Carcinoma with Cobalt-60 Teletherapy—George P. Koeck, M.D., William V. Tenzel, M.D., Lillian E. Jacobson, M.A., and William R. Hillsinger, B.S., Presbyterian Hospital Unit of United Hospitals of Newark

The exhibit highlights localization of nodes and treatment planning. Tangential ports are used for the chest wall and internal mammary chains; direct ports for the clavicular-axillary areas. Contour making, dosage calculation, isodose distributions and results to date are presented.

Booth S-240. Precision Cone Therapy of Oral Carcinoma—An End Result Study Based on 17 Years of Experience—S. Gordon Castigliano, M.D., and C. Jules Rominger, M.D., American Oncologic Hospital, and Misericordia Hospital, Philadelphia, Pa.

This exhibit describes the use of precision individually tailored oral cones in the primary management of oral malignancies. Seventeen years of experience have demonstrated the efficacy of this method of controlling the primary lesion in a variety of clinical settings: tongue, floor of mouth, gingivae, buccal surface, tonsil, palate, and antrum. An end result study is presented.

Booth S-241. Radium Research Project—Lester A. Barrer, M.S., Hyman W. Fisher, M.D., Carye-Belle Henle, M.D., and Robert Bonda, D.D.S., Radium Research Project, New Jersey State Department of Health, West Orange

Here is an exhibit to illustrate the various phases of an epidemiologic follow-up of individuals with significant body burdens of radium and some of its isotopes. Illustrated by case histories are our efforts to study the relationship between a body burden and the medical and dental effects.

Educational Exhibits

Exhibit Hours: 1:00 p. m. - 5:00 p. m., Sunday, May 14, 1961
9:00 a. m. - 5:00 p. m., Monday and Tuesday, May 15 and 16, 1961
9:00 a. m. - 1:00 p. m., Wednesday, May 17, 1961

Booth E-101. The Academy of Medicine of New Jersey—Bloomfield

Display of activities of the Academy of Medicine of New Jersey.

Booth E-102. The Changing Role of the School Physician—Committee on Child Health, The Medical Society of New Jersey, Trenton.

Photographic portrayal of the changing role of the school physician from medical examiner to consultant in mental and physical health. His new functions will be shown to correlate the needs of the child with the goals of the educators.

Booth E-103. Consultation Service for Convulsive Disorders—New Jersey Consultation Service for Convulsive Disorders, Princeton

The New Jersey Consultation Service for Convulsive Disorders offers professional consultation for patients suffering from convulsive disorders, who cannot pay the usual private fees for such service. Clinics are held in designated local hospitals throughout the state.

Booth E-104. Future Physicians Club of Essex County—Essex County Medical Society, East Orange

This exhibit shows the activities of the Future Physicians Club of the Essex County Medical Society and its program for the Active Future Physicians Clubs already established in 38 Essex County High Schools. Literature is available on the objectives of the Club. Also shown will be pamphlets aimed at stimulating high school students to select premedical courses.

Booth E-105. Lung Cancer Prevention and the Physician—American Cancer Society, New Jersey Division, Inc., Newark

Through charts and other displays, the exhibit depicts the high lung cancer death rate today and the possible loss from the disease of more than one million of today's school children before they reach the age of 70. This prospect is of particular concern to the physician. The exhibit considers the role of the physician in the prevention of lung cancer and the efforts of the Society to this end. It is hoped the exhibit will stimulate the interest and support of physicians in our teenage smoking program.

Booth E-107. Medical Public Relations . . . and YOU—Council on Public Relations, The Medical Society of New Jersey, Trenton

This exhibit is planned to acquaint the members of The Medical Society of New Jersey with the publications and programs of the Council on Public Relations. It is also intended to identify and emphasize the principles, concepts, and activities essential to successful public relations for medicine.

Technical Exhibits

Exhibit Hours: 1:00 p.m. - 5:00 p.m., Sunday, May 14, 1961
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 15 and 16, 1961
9:00 a.m. - 1:00 p.m., Wednesday, May 17, 1961

Abbott Laboratories **Booth 33**

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

American Mutual Liability Insurance Co. **Booth 13**

The new professional liability insurance program depends on the operation and success of "Loss Control." This phase of the program gives each society the opportunity to help control and prevent losses, which has never been available in the past. One of the tools for loss control is the consent form and a booklet of such forms to be used for most situations will be available for each delegate or guest.

American Sterilizer Company **Booth 5**

A. R. E. **Booth 48**

A.R.E.'s display of rehabilitation equipment include the "Kim Stander," E & J wheel chairs and Safety Bath. This is one of the first of its kind in New Jersey handling a complete line of physical therapy and physical restoration rehabilitation equipment at The Annual Meeting of the Medical Society of New Jersey. Our representative will be happy to answer all questions about equipment shown as well as about others not here displayed including hydrocolators, exercise bars, porto lifts, scales, and trapezes.

Ayerst Laboratories **Booth 26**

A cordial invitation is extended to you to visit the Ayerst Laboratories' booth where we will be featuring: Plegine®, a brand of phendimetrazine bitartrate, which will fulfill your patients' requirements for an appetite suppressant; Riopan®, a brand of monalium hydrate, a true buffer antacid; and Thiosulfil A®, a brand of sulfamethizole with phenylazo-diamino-pyridine for treatment of urinary tract infections when analgesia is desired. Our representative will be on hand to discuss with you these products and to offer any information you might desire on any of our other products.

Baby Service, Inc. **Booth 72**

New Jersey's largest diaper service will once again be on hand to welcome all who stop to say "hello." The latest in diaper processing, styles and improvements will be available to the doctor; and there will be the usual Baby Service rose for each lady who calls at Booth 72.

The Baker Laboratories, Inc. **Booth 53**

You are invited to visit Booth 53 where Baker's Modified Milk and Varamel®, two successful products for infant feeding are on display. Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

E. & W. Blanksteen Agency, Inc. **Booth 3**

At this booth, you will find information and literature regarding The Medical Society of New Jersey plans of accident and health and life insurance.

The Borden Company **Booth A**

Featuring Borden's new pediatric creme Methakote® for the treatment of diaper rash in all degrees of severity. Eliminates B. ammoniagenes, the causative factor and prevents staphylococcic and other secondary invaders. The added sulphur bearing amino acids accelerate wound healing at site of lesion. Complete information on Methakote® and our infant formulas, Bremil® and Mull-Soy®, is available at Booth A through our courteous representatives.

Bristol Laboratories,
Division of Bristol Myers Company **Booth 12**

The Bristol Laboratories exhibit will feature the new synthetic penicillin, Staphcillin®. Following Syncillin®, Staphcillin® is the second synthetic penicillin to be developed. Information about its specific use for infections due to "resistant" staphylococci will be conveyed by means of graphs and charts as well as by discussion with professional representatives.

Brunswick Surgical Supply Co., Inc. **Booth 66**

Brunswick Surgical Supply Company will feature several new electronic medical devices. The Diapulse Machine manufactured by Remington Rand will be demonstrated by factory trained technicians. The Kinenometer, the new method of basal metabolism determination used in conjunction with any electrocardiograph will be in operation. A new approach to office autoclaving will be on display. A cordial welcome from our field service staff awaits you at booth 66.

Burroughs Wellcome & Co. (U.S.A.), Inc. **Booth 57**

Cameron Surgical Instruments Company **Booth 64**

The Cameron Company usually has some new instruments and this year is no different. They are the new *Electrified Biopsy Punch*—the rotating Cameron Lempert safety Headlite for operating rooms—two new lighter-weight electro-surgical units for office and clinic and a brand new *Major* surgical unit for the operating room.

G. W. Carnrick Company **Booth 9**

The G. W. Carnrick Company welcomes you to our booth which will feature Midrin® capsules. The new product relieves migraine, migraine variants and "tension headaches" by reducing intracranial pressure and throbbing, emotional stress and cephalic pain. Bontril® Timed, the triple-layer, triple-release tablet provides maximum anoretic activity at the hunger peaks. Nolamine® tablets, Elixir and Expectorant are available for rapid and more prolonged relief of nasal congestion. Penite® Sustained capsules, the more effective coronary vasodilator will also be displayed.

Ciba Pharmaceutical Products, Inc. **Booth 23**

Forhistal® is a new, low-dosage antiallergic and antipruritic agent. Clinically, Forhistal® has proved highly effective in a wide range of allergic and pruritic disorders. It is well tolerated by patients of all ages. Forhistal® is available in four forms of issue: Lontabs®, tablets, syrup and pediatric drops.

The Coca-Cola Company **Booth 47**

Ice-cold Coca-Cola® will be served at Booth 47 through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City, and The Coca-Cola Company.

Desitin Chemical Company **Booth 35**

Desitin® Ointment is the pioneer Cod Liver Oil ointment for the treatment of burns, ulcers, diaper rash and abrasions. Desitin® Powder, saturated with Cod Liver Oil is dainty, relieves chafing, sunburn and diaper rash. Desitin® Hemorrhoidal Suppositories, and Rectal Ointment, relieve pain and itching, promote healing, give comfort in uncomplicated hemorrhoids or fissures. They contain no anesthetics or styptics. Desitin® Baby Lotion, a protective, antiseptic, emollient, contains no mineral oil. It cleanses baby skin with tender care. Desitin® Acne Cream is a non-staining, flesh-tinted "Medicream" for the treatment of acne vulgaris and skin blemishes. It is effective and antiseptic in removal of skin oiliness. Desitin® Cosmetic and Nursery Soap is supermild, pleasantly scented, antiseptic, and deodorant.

The Dietene Company **Booth 41**

Have you tasted Meritene®? Meritene® is the good-tasting *Protein*-vitamin mineral food supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit Booth 41 and let us serve you a cool, refreshing Meritene® nourishment. While there, review our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs. Meritene® and Dietene are advertised only to the medical profession.

Doho Chemical Corporation **Booth 61**

Seen at Booth 61 will be: Auralgan®, an ear medication for relief of pain in otitis media; and for the removal of cerumen.

Rhinalgan®, a nasal decongestant free from systemic or circulatory effect. It is safe for infants and the aged.

Otosmosan®, a non-toxic fungicide-bactericide (gram negative-gram positive) for suppurative and aural dermatomycotic ears.

Larylgan®, a soothing throat spray and gargle for infectious and noninfectious sore throat involvements.

Biotosmosan HC®, is the solution to the "Problem Ear." It is antimicrobial, anti-inflammatory, de-inflammatory, anti-allergic, and antipruritic.

Eaton Laboratories **Booth 67**

New—Furadantin® Sodium for intravenous use. After more than 8 years of extensive use in the treatment of urinary tract infections, Furadantin® enjoys an enviable reputation as a safe, broad-range bactericide that has little or no tendency to invoke resistant mutants. The utility of this antibacterial is now enhanced by the addition of a water-soluble, parenteral dosage form—Furadantin® Sodium for intravenous use. Our representatives will supply you with complete information.

Thomas A. Edison Industries **Booth 29**

Edison Voicewriter—"Dictation Center U.S.A." —will show a complete line of business recording equipment: Edison Voice writer M-E models . . . full-featured dictating instruments for executive and secretarial use; Escort . . . battery-operated, portable dictating instrument; Envoy . . . budget-priced magnetic tape dictating-transcribing machine; Midgetape . . . battery-operated pocketsize tape recorder; Televoice . . . phone network dictating systems.

Encyclopaedia Britannica, Inc. **Booth 21**

WORLD-FAMOUS

SO—fascinating, so different; unlike anything else. Brilliantly alive in color. The brand new 1961 Edition of Encyclopaedia Britannica is now on display at booth 21 at tremendous discount at this convention to doctors. This discount cannot be offered after the close of your annual meeting.

Geigy Pharmaceuticals **Booth 24**

Geigy cordially invites members and guests of the society to visit booth 24. The exhibit features important new therapeutic developments in the management of inflammation, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

Geriatric Pharmaceutical Corp. **Booth 1**

The Geriatric Pharmaceutical Corp. will exhibit the first break-through in gastro-intestinal enzymes, Gustazyme® and Bilezyme®. Gustazyme® contains a new enzyme that will digest roughage, such as cucumber, celery and cabbage. It offers a new proteolytic and starch enzyme which is active throughout the whole gastro-intestinal tract from the stomach through the colon.

Bilezyme® contains dehydrocholic and desoxycholic acid in addition to the proteolytic and amylolytic enzymes for the management of liver and gall bladder involvements, especially indicated in the post-cholecystectomic syndrome.

Great Books of the Western World **Booth 4**

A new advancement in liberal education, spanning 3,000 years of Western Thought, from Homer and the Bible to the 20th century featuring the master key to the Great Books: *The Syntopicon.* The revolutionary Syntopicon is a totally new basic reference work. It does in the field of ideas what the dictionary does for words and the encyclopedia does in the field of facts.

Health Insurance Council **Booth B**

The Health Insurance Council serves, on behalf of the nation's insurance companies, as a central source of information and counsel to physicians, hospitals, and others in the health care field on all aspects of health insurance. The Council seeks to promote cooperation and understanding between those who provide health care and those who help finance its cost . . . to the end that the insurance business may provide the most effective and satisfactory health insurance protection possible.

Holland-Rantos Company, Inc. **Booth 62**

Johnson & Johnson **Booth 16**

Displayed in booth 16 will be the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest: Surgical Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism; Dermicel® Surgical Tape, a special-purpose dressing tape for patients with unusual adhesive tape sensitivity. Other products, designed for your office, hospital, or patient use, also will be displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Kessler Associates, Inc. **Booth 49**

Kessler Associates, Inc., again will display the latest types of prosthetic appliances including the complete process of manufacturing the Patellar Tendon Cuff Suspension Prosthesis, and the latest developments in pneumatic arms. Your discussion of any prosthetic problem is welcomed.

Knoll Pharmaceutical Company **Booth 34**

You may now prescribe fruit-flavored, taste appealing Quadrinal® suspension for asthma patients who prefer a liquid to the time proved Quadrinal® tablet. Dilaudid® is for pain that synthetic analgesics frequently fail to relieve; also for "the cough that must be controlled." Metrazol®, Vita-Metrazol®, and Nico-Metrazol® elixir and tablets are for the geriatric and convalescent patient. Akineton® is our new antiparkinsonism agent.

Lamond Products, Inc. **Booth 50**

Lamond Products will feature dermatologics exclusively. A new product will be introduced: Sebana® Shampoo, an antiseborrheic shampoo that removes all dandruff and excess sebum from the scalp.

Other products featured are: Bur-Zin® (Burow's Emulsion) for eczematous eruptions; Bur-Cort®, a superior topical hydrocortisone emulsion; Dermasorcin® and Dermasul®, flesh-tinted, medicated (sulfur and resorcin) lotions for acne and seborrhea; Dermastringe®, tincture containing salicylic acid and resorcin for seborrhea and skin cleansing purposes; and for the summer—Sunprotectol®, the best sun screening lotion, that aids in tanning without allowing the burning rays to harm the skin.

Lederle Laboratories **Booth 56**

Your Lederle representative will be on hand to serve you. He can furnish information on any Lederle product and is prepared to bring to bear on any of your medical problems the knowledge of the world-wide Lederle research organization.

Eli Lilly and Company **Booth 28**

You are cordially invited to visit the Lilly exhibit at booth 28. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

P. Lorillard Company **Booth 69**

P. Lorillard Company invites you to visit the Kent Cigarette exhibit. We are presenting the

"Story of Kent Cigarettes." And a big part of that story is why you'll feel better about smoking with the taste of Kent. Kent with the Micronite® filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild. A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the convention.

Maltbie Laboratories **Booth 60**

Maltbie Laboratories features the unique tranquilizer compound, Dornwal®, that works for greater therapeutic effect without causing sedation. Also displayed are: Caldecort®, an antifungal, antibacterial, anti-inflammatory dermatologic ointment; Desenex®, for athlete's foot; Nesacaine®, a safe, potent and rapid-acting local anesthetic; Cholans®, for hepato-biliary dysfunction; and Caldesene® Medicated Powder for diaper rash.

The S. E. Massengill Co., Inc. **Booth 58**

Best wishes from Massengill to The Medical Society of New Jersey for a most successful 1961 meeting! Massengill representatives will be honored to discuss any products of interest to you. On display will be Trimagill®, the outstanding new product for vaginal therapy; Massengill Powder, the preferred vaginal douche; Adrenosem®, the unique systemic hemostat; Obedrin®, superior reducing-aid; Homagenets®, the only solid homogenized vitamins; Livitamin®, the hematinic of choice; and products of the Salcort-Predsem® Group, for the complete range of arthritic therapy. Of course, literature and samples will be available should you desire them.

McNeil Laboratories, Inc. **Booth 14**

Mead Johnson Laboratories **Booth 55**

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medco Products Co. **Booth 8**

From the laboratory that produces the Medcolator® and the Medco-sonlator® comes another notable first. Medco brings you the Kol-Therm®. An ingenious application of two proved therapies, cold and heat which may now be efficiently applied, either moist or dry, manual or automatically from 30 degrees cold to 130 degrees heat. Also on exhibit the famous Medcolator®, neuro-muscular stimulator and the new concept in therapy, the Medco-sonlator®, which combines diagnostic and therapeutic qualities.

Medical Management of Central New Jersey, Inc. **Booth 7**

Medical Management offers a general consulting service on the business aspects of a physician's practice. Also available (and displayed in booth 7) is a highly developed *Accounts Receivable Control and Billing System*. Considerably more than just another method of billing, this system gives the doctor complete control of his accounts, improves patient relations and increases his collection ratio. Statements are prepared and delinquent accounts automatically followed up. Rigid accuracy is assured by the use of IBM data processing machines.

Medical-Surgical Plan of New Jersey **Booth 15**

This exhibit of Medical-Surgical Plan of New Jersey (New Jersey Blue Shield Plan) will stress the Plan's accomplishments in Public Relations . . . with special reference to its efforts to win due public recognition of the contribution being made by the medical profession in the field of voluntary pre-paid medical-surgical care.

Illustrations of planned publicity material, and newspaper coverage thereof, will be a highlight. The display also will feature examples of newspaper and radio campaigns aimed at bringing about general public recognition of the medical profession's role in health care through Blue Shield, and pointed toward delineation of the separate identities of Blue Shield (for doctor bills) and Blue Cross (for hospital bills).

Included in the display will be examples of direct-mail literature aimed at convincing the "opinion-molding" public of the important role played by the medical profession in providing, through Blue Shield, the best of health care at the lowest practical price.

The display also will set forth statistics concerning payments by the Plan to doctors for medical-surgical care (more than $31 million in 1960) of the more than 2 million Blue Shield subscribers.

Blue Shield cordially invites physicians and their wives to visit its display and talk with Plan representatives, who will be glad to answer any questions pertaining to the Plan.

Merck Sharp & Dohme **Booth 39**

Featured at booth 39 is Lyovac® Thrombolysin fibrinolysin (human) to promote the dissolution of certain intravascular thrombi. Striatran® is effective in relieving the anxiety and tension associated with a variety of clinical situations. Decadron® is valuable for symptomatic treatment in patients with allergic and inflammatory disorders. Technically trained personnel will be present to discuss these and other subjects of clinical interest.

The Wm. S. Merrell Company **Booth 65**

Merrell will present at Booth 65 a summary of mounting clinical evidence attesting to the effectiveness of Mer/29® in patients with hypercholesterolemia and related conditions. Update your knowledge of Mer/29® by stopping briefly at the Merrell display. Salesmen will summarize the extensive results of Mer/29® therapy for you and answer questions you may have. Best wishes for a most enjoyable convention!

Milex of New York — Booth 17

Gynecologic products will be featured in Booth 17. These include Trimo-San® for trichomonas, monilia, and mixed leukorrheas. Amino-Cerv Gel® will be demonstrated as the treatment of choice for cervicitis and post-cervical surgery. Samples of *A Doctor Discusses Menopause* and *A Doctor's Marital Guide* will be available upon request. New developments in the Milex Cancer Detection Program will be surveyed. Please stop in and say, "Hello."

The National Drug Company — Booth 19

Tepanil® and Orenzyme® are being featured at Booth 19. Tepanil® is a completely new compound that curbs the appetite with little or no central stimulation. Orenzyme® is the first oral anti-inflammatory enzyme tablet on the market. Orenzyme® is indicated for the treatment of any acute inflammatory process when swelling slows recovery.

Organon, Incorporated — Booth 52

Physicians are cordially invited to visit the Organon booth for information on useful therapeutic specialties. Included among these will be: Durabolin®, a safe, potent, long-acting anabolic stimulant indicated in all conditions where a tissue-building is desired. Durabolin® provides its potent tissue-building effects without the drawbacks and dangers characteristic of tissue-building steroids. No masculinization occurs in recommended dosages. It is administered only once each week. Organon representatives will gladly discuss these specialties with all interested physicians.

Ortho Pharmaceutical Corporation — Booth 54

Ortho is proud to present the most complete line of products for the control of conception. Representatives are showing the Ortho Arcing Spring Diaphragm, the most recent advance in this field. For those patients not suited to the diaphragm method, Ortho representatives will be happy to discuss the use of Delfen® Vaginal Cream and Preceptin® Vaginal Gel for use with an applicator. Also on display will be the new Sultrin® Cream, a reformulation of Triple Sulfa® Cream into a white emollient therapeutic for various forms of vaginitis.

Pfizer Laboratories — Booth 70

You are cordially invited to visit the Pfizer Laboratories' exhibit at Booth 70 where our professional service representatives will be pleased to discuss the latest topics of clinical interest.

The Purdue Frederick Company — Booth 40

Cardioquin® Tablets represent a new polygalacturonate salt of quinidine, indicated for cardiac arrhythmias. They minimize the gastro-intestinal irritation produced by conventional quinidine salts by dissociating slowly and avoiding the high concentration of quinidine ions responsible for this irritation, yet producing the full therapeutic effects of quinidine required for rapid induction and maintenance. Senokot® Granules and Senokot® Tablets are standardized concentrate of total senna pod principles used in the management of constipation. Correction of constipation is physiologically gentle and neurogenically persuasive. Senokot® Granules are pleasantly cocoa flavored. Product samples and Product Data Brochures containing detailed information for use, dosages, precautions, and contraindications will be made freely available to attending physicians at the Purdue Frederick booth.

A. H. Robins Company, Inc. — Booth 32

Nine out of ten of your nasal allergy patients may benefit from your visit to the Robins booth to hear about Dimetane®. Its antihistaminic potency and paucity of side effects are unsurpassed. Robins representatives will also gladly explain the advantages of Donnagel® (in diarrhea), Ambar® (for overweight), Naclex® (in edema and hypertension), and other ethical Robins products.

Roche Laboratories — Booth 42

Librium®—a therapeutic agent for superior, safer, faster control of "nervousness," anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

Tigan®—a specific antiemetic agent effective both prophylactically and therapeutically against most clinically significant types of nausea and vomiting.

Madribon®—is a completely different, low-dosage sulfonamide of particular value in the treatment of bacterial infections especially respiratory infections.

J. B. Roerig and Company — Booth 59

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be at Booth 59 to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

William H. Rorer, Inc. — Booth 20

Maalox®, a pleasant tasting, non-constipating antacid is featured in liquid, tablets and Maalox No. 2® (double strength) tablets. Also highlighted are Ascriptin®, a professional salicylate for pain of arthritis, Fermalox®, a non-irritating, uncoated, buffered ferrous sulfate tablet, and Parepectolin®, a pleasant tasting antidiarrheal preparation of paregoric, pectin and kaolin. Representatives will gladly answer questions concerning Rorer products.

Ross Laboratories **Booth 25**

Ross Laboratories, who also manufactures, Similac®, features Similac® With Iron, a new prepared infant formula supplying 12 milligrams of ferrous iron per quart of formula. Similac® With Iron is designed for use at the time exogenous iron is indicated in infancy to support the usual diet and to provide prophylaxis against iron deficiency during the period of greatest incidence, from 6 to 18 months of life. Some special indications for use are following placental or traumatic blood loss, for prematures and twins, for the pallid, irritable, anorectic infant with an unsatisfactory blood picture and following prolonged infection or diarrhea.

Rystan Company **Booth 6**

Rystan introduces a new anti-inflammatory enzyme, Buclamase®, for the management of swelling and pain of sprains, fractures, bruises and other orthopedic or postoperative conditions. A development of original Rystan research, Buclamase® is a buccal tablet containing the amylolytic enzyme, alpha amylase. Safe, inexpensive and convenient, Buclamase® is particularly suited to routine, on-the-spot administration for injuries sustained in organized sports programs.

Sandoz Pharmaceuticals **Booth 38**

Mellaril® is the first selective phenothiazine exhibiting potent tranquilizing activity without antiemetic action. The greater toleration (notably relative absence of extra pyramidal symptoms) enhances its usefulness in management of major and minor emotional disorders. Plexonal® is the preferred day time sedative-relaxant. Syntocinon® Nasal Spray is a new preparation for intranasal application of synthetic exytocin (Syntocinon®). It activates the milk-ejection reflex to stimulate milk letdown and overcomes some of the complications associated with lactation e.g. engorged, painful tender or distended breasts due to milk retention and stasis or the circumscribed, painful induration of incipient mastitis. It accelerates involution of the uterus.

W. B. Saunders Company **Booth 36**

New Saunders books published since last year's meeting include: Current Therapy 1961; Nagan: Medical Almanac; Edwards: An Atlas of The Heart and Great Vessels; Mills & Moyer: Connective Tissue; and Beckman: Pharmacology.

Schering Corporation **Booth 18**

You are cordially invited to visit the Schering technical exhibit where information on the following products may be obtained: Naqua®, effective oral diuretic—and antihypertensive; Diloderm®, first chlorinated steroid with specific topical effectiveness; and Chlor-Trimeton®, unsurpassed antihistamine.

Julius Schmid, Inc. **Booth 2**

An interesting and informative exhibit featuring Immolin® Vaginal Cream-Jel for use without a diaphragm; Ramses Flexible Cushioned and Bendex® Diaphragms; Ramses® Vaginal Jelly; Vagisec® Jelly and Liquid for vaginal trichomoniasis therapy; and XXXX (Fourex)® Skin condoms, Ramses®, Sheik®, and Esquire® Rubber condoms for the control of trichomonal re-infection.

G. D. Searle & Co. **Booth 22**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be our new products, Aldactazide®, Lomotil®, and Enovid®.

Smith Kline & French Laboratories **Booth 10**

Our representatives welcome the opportunity to discuss SK&F products with you and are ready always to be of help in any way they can. Products featured at this meeting are: (1) Eskatrol Spansule® capsules, (2) Ornade Spansule® capsules, and (3) Stelazine®.

South Jersey Surgical Supply Co. **Booth 27**

South Jersey Surgical, this year will display for the first time at the annual meeting of The Medical Society of New Jersey, a new concept in professional office equipment. American Modular, unique and beautiful in appearance is designed to your individual needs. Don't miss this display; you have seen nothing like it before.

E. R. Squibb & Sons **Booth 31**

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for the prevention and treatment of disease. The results of our diligent research are available to the medical profession in new products or improvements in products already marketed. At Booth 31, we are pleased to present up-to-date information on these advances for your consideration.

William Allen Steadman & Company **Booth 11**

William Allen Steadman & Company were the originators of complete financial service to the medical profession. This company is the investment adviser and the underwriter for Steadman Investment Fund, Inc. It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians in order to provide financial and investment assistance from internship through retirement. Physicians and their wives are cordially invited to visit the booth.

S. J. Tutag & Company **Booth 63**

At Booth 63, S. J. Tutag & Company introduces a new anti-obesity agent for prompt and emphatic

hunger control—with little, if any, central nervous system stimulation. Cydril® is a new chemical compound that possesses anorectic action with low toxicity. It is available in two forms: tablets and the sustained-release Tutag Granucap®. Adults and children over 12 years take one Cydril® tablet three times daily, preferably ½ hour before meals, or one Cydril® Granucap in the morning.

The Upjohn Company — Booth 71

Professional representatives of The Upjohn Company are eager to contribute to the success of this Annual Meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments: Booth 71.

U. S. Vitamin and Pharmaceutical Corporation — Booth 43

DBI®, a new "full-range" oral hypoglycemic agent, is a brand of phenformin (N -B-phenethyl-biguanide HCl). It is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas. It effectively lowers blood sugar and eliminates glycosuria in mild, moderate and severe diabetes. DBI®, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes. In juvenile diabetes, DBI® often permits up to 50 per cent reduction in insulin requirement. It is effective in the insulin-resistant, and in primary and secondary tolbutamide and chlorpropamide failures. Full details will be available at Booth 43.

Walker-Gordon Laboratory Company — Booth 46

You are invited to taste-test Walker-Gordon Certified milks. You will find the new Certified Lo-Sodium Milk especially processed to reduce its sodium content from around 500 to less than 50 milligrams per quart. Walker-Gordon Acidophilus Milk, Certified Pasteurized Milk, and Certified Skimmed Milk will also be available. The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, N.J., is the world's largest farm producing Certified Milk. It includes over 2,400 acres of farm land and 2,690 cows and growing heifers. It is the home of the famous Rotolactor, which makes possible the production of the highest quality milk. Walker-Gordon Certified Milk is distributed in the metropolitan area of New York and Philadelphia and in the state of New Jersey by many leading milk dealers.

Wallace Laboratories — Booth 51

This year the Wallace Laboratories (Cranbury, N.J.) exhibit is on Soma® Compound, a new analgesic for the relief of pain, tension and fever in neuralgias, dysmenorrhea, upper respiratory distress, post-surgical conditions in which pain, tension and fever are symptons. It contains Soma®, a new type of analgesic that has proved highly effective in relieving both pain and tension; phenacetin, and caffeine. For relief of pain in more severe cases, Soma® Compound with Codeine adds to the above ¼ grain of codeine phosphate Since Soma® Compound potentiates the effectiveness of codeine, only ¼ grain is required to relieve the more severe pain that usually requires ½ grain.

Warner-Chilcott Laboratories — Booth 30

Gelusil® is the physician's antacid for the relief of gastric hyperacidity and management of peptic ulcer. It provides two protective coating gels for prompt, prolonged relief of pain. Gelusil® is all antacid in action. It is non-constipating, and contains no laxative. Also shown will be Peritrate®, a long-acting coronary vasodilator for patients with coronary artery disease—whether angina pectoris or coronary occlusion. Peritrate® improves coronary blood flow, thereby increasing collateral circulation, with no significant change in blood pressure or pulse rate. Smooth onset of action virtually eliminates nitrate headache.

Warren-Teed Products Co. — Booth 37

The Warren-Teed Products Company will feature the following pharmaceutical specialty products at their exhibit: Ilopan®—an injectable d-pantothenyl alcohol for the treatment and prevention of flatulent gastro-intestinal distention. Modane®—more than a laxative—for rehabilitation and relief of the atonic bowel. Ilomel® Powder—anti-ulcerogenic plus classic antacid management of peptic ulceration. Ilocalm® Tablets—anti-ulcerogenic plus classic anti-cholinergic management of peptic ulceration. Warren-Teed representatives cordially welcome all registrants to visit their display.

Westwood Pharmaceuticals — Booth 45

Westwood invites physicians to stop by their booth to discuss their unique dermatologic products: Fostex® Cake, Fostex® Cream, Lowila® Cake, Lowila® Emollient, Sebulex®, Fostril®, and Alpha Keri®. These preparations are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories, Inc. — Booth 44

Winthrop Laboratories — Booth 68

Alvodine® is a new potent narcotic analgesic that relieves pain without causing drowsiness or hypnosis (in over 90 per cent of patients). It is especially well suited for postoperative use, for pain from cancer, angina, cholecystitis, pleurisy, myocardial infarction; and for pre-operative preparation and as a supplement to anesthesia. Alvodine® is available in scored tablets of 50 milligrams and ampuls of 20 milligrams (1 cubic centimeter.) It is subject to the Federal Narcotic Law.

Annual Reports of County Societies • • •

Bergen

GEORGE O. ROWOHLT, M.D., President, Dumont

Bergen County continues to grow in population; the most recent estimate places our census at over 800,000. With the addition of 48 new doctors, our membership has reached 752 of whom 609 are Active members, 50 Associate, 40 Courtesy, 24 Emeritus, 4 Honorary, 17 "Over Seventy," and 8 Leave of Absence. One application was rejected and one postponed.

Nine Society meetings were held during the past year:

April, 1960—Relative Value Schedules—Dr. Irving Klompus

May, 1960—"What's Doing in Medicine?"—Dr. F. Clyde Bowers

June, 1960—Installation Dinner

September, 1960—Points of View on Pending Federal Legislation—Hon. Frank C. Osmers, Jr., Mr. Vincent T. McKenna

October, 1960—Business Meeting

November, 1960—Unusual X-rays of the Chest—Dr. Emanuel Klosk, Dr. Coleman, Dr. Rabin, Dr. John L. Olpp, Dr. Wm. L. Palazzo and Dr. Herbert S. Sharlin

January, 1961—Perspective on Fall-Out—Dr. Frank G. Dunnington

February, 1961—Lung Cancer and Smoking—John F. W. King, Dr. E. L. Wynder, Dr. Oscar Auerbach, Dr. Daniel Horn and Dr. Samuel M. Fox

March, 1961—Activities of the National Institutes of Health

The inclemency of the weather forced cancellation of our December 1960 meeting. This is the first time in our recent history that Mother Nature has been so unkind, although during the 107 years of our existence, there surely must have been similiar occasions. The "Debate" between both political party candidates for our Representative in Congress was of special interest. It was the first such meeting in the campaign.

A public forum co-sponsored by *The Record* was held in November 1960 on "Diabetes." Dr. J. John Kristal was moderator, and Dr. Henry Dolger, Chief of the Diabetes Service of New York's Mt. Sinai Hospital, was guest speaker. In March 1961, another public symposium, "A Team Approach to School Health Problems" was organized and promoted by our active School and Child Health Committee, some of whose members served on the Bergen County School Health Liaison Committee. This latter committee was responsible for the compiling and publishing of a brochure, "Recommended Standards for School Health Services." This has met with wide acclaim throughout the State and has been of more than passing interest to the State Department of Education. Bill S-66 is an outgrowth of the activity of this committee. A third public forum on "Compulsory Government Medical Care For You?" co-sponsored by the *Passaic-Herald News,* was held in May 1960. Due to extremely inclement weather, this excellent discussion was heard by a disappointingly small audience.

The Bergen County Medical Society Code of Medical Ethics, originally written in April 1929, revised January 1938, was again revised. Two new sections were appended: "Information for New Members" and "Additional General Information."

The organization of the "Medical Review and Advisory Committee," recommended by the Trustees of the State Society and its "Committee on Medical Defense and Insurance" is nearing completion. The committee will be composed of 25 members including officers of the County Society, representatives from each of the specialties and general practice, and a layman as a voting member.

Our Emergency Medical Service, now in its third year, under the aegis of the Community Service Committee and run at the expense of the County Society, continues to function efficiently. All calls were satisfactorily concluded.

The Speakers' Bureau fulfilled 24 engagements on various subjects, the most popular being "cancer." This was discussed on seven occasions. The Bureau also arranged five courses of ten lectures each for adult education programs, as well as a course of four lectures on traumatic emergencies for the personnel of the Volunteer Ambulance Corps, comprising the 3rd District of the N. J. State First Aid Council.

In addition to the Emergency Medical Service and the Speakers' Bureau, our Community

Service Committee prepared four news releases on this committee's services plus Information Service and Judicial Committee. These releases were published in the local press as a series of feature articles and inspired wide public interest.

The name of one committee was changed to "Disputed Insurance Bills Committee." Its duties were expanded to include *all* types of insurance bills instead of being limited to compensation only.

An *ad hoc* committee on the Relative Value Index was formed. This committee will send each member an informational letter with an enclosed card to be returned indicating approval or disapproval of the "Index" on a state-wide basis. This was done primarily to guide our delegates if R.V.I. comes to a vote at the Annual Meeting of The Medical Society of New Jersey.

The Physician's Welfare and Relief Committee circularized the members on several questions on the basis of which an augmentation may be proposed.

An "Athletic Injury Committee" was organized. This joint committee consists of members of our Society plus representatives of the Bergen County Coaches Association. A symposium will be held after necessary research has been completed.

During the year, a decision regarding the ethical propriety of selling, bartering, or exchanging for profit, physicians' samples was requested from our local and State Judicial Committees. In both cases, the opinion was that such activities are unethical and unprofessional.

The following is a recapitulation of the cases considered by the Judicial Committee between April 1, 1960 and March 31, 1961.

Total cases considered	22	Types of Cases:	
Cases closed	20	Fee	9
Cases pending	2	Medical care	7
		Conduct of doctor	1
		Ethics	5

Our *Bulletin*, under its able editorship, continues excellent in form and context. Between covers, it has averaged over 40 pages of copy covering any newsworthy or editorial matter of interest to physicians except scientific articles. It has been printed and mailed at a little better than the break-even point of cost.

The Woman's Auxiliary gave a "Monte Carlo Night" party from the proceeds of which they were able to contribute $1,336.88 to our Student Loan Fund. There is now a sum of $3,500 loaned to 4 medical students. The Auxiliary held its Second Annual Health Forum for the public on March 28, 1961, on 3 major health problems—heart disease, cancer, and financing health care. The panel consisted of Society members and Mr. Richard I. Nevin, Executive Officer of our State Society.

It was decided that the time has come for the Society to increase the number of its officers. The title of "president-elect" now gives us four presidential offices and will provide additional and badly needed assistance to our presidents in the future. The president-elect will become chairman of the new medical review and advisory committee.

Burlington

Norman K. Boudwin, M.D., President, Beverly

The Burlington County Medical Society resumed monthly meetings in September 1960. Programs covered the following subjects: multiple sclerosis; pediatric orthopedic problems; new virus diseases; the doctor and the press; endocrinology; ulcerative colitis; and the Medical Examiner.

Our meetings have been well attended, and the subject matter has been excellent, thanks to our Program Chairman, Robert Heal, M.D.

Seventeen new members have been elected into our Society since September.

This year we instituted a change in the format of our monthly *Newsletter*. This has been well received by the membership at large.

The Public Relations Committee, in cooperation with the Secretary and the Editor, have distributed a copy of our Physicians' In-

formation Directory to each County Society Secretary. This has been a help to older members and new members arriving in our County.

At our December 1960 meeting, representatives of the press aired several problems and matters which should promote better public relations between the physician and the press.

The annual doctors'-lawyers' dinner meeting was held in February 1961 with an excellent representation by both professions. The subject of "The Medical Examiner" was discussed very thoroughly by Joseph W. Spelman, M.D., Medical Examiner for the City of Philadelphia, Pa.

Our immediate past,-president, Robert E. Haldeman, M.D., died in December. This was a grievous loss to our Society and his memory will live with us for a long time.

Essex

Samuel W. Ebenfeld, M.D., President, Newark

During my administration, I have selected speakers at our regular meetings on the various aspects of the economics underlying modern medicine.

Last October, we had a highly successful dinner meeting with our Woman's Auxiliary at which Dr. Jesse McCall, President of The Medical Society of New Jersey, spoke on "What Organized Medicine Means to the Future Practice of the Physician." Mr. Albert Cole, Group Supervisor of the United States Internal Revenue Service, talked at our November meeting about the examination functions of the internal revenue service.

Our January meeting was a panel discussion entitled, "The Physician as a Witness in Court Proceedings." This was set up jointly with the Essex County Bar Association. The three panelists were practicing trial attorneys and members of the Essex County Bar Association. Dr. Henry A. Davidson was the moderator. This session did much to improve our interprofessional relationships and we hope to have more meetings of this type.

C. Willard Camalier, M.D., a past chairman of the medical economics committee of The Medical Society of the District of Columbia, addressed our March meeting on "The Relative Value Index and How It Affects Your Fees." Dr. Camalier was well suited to present this, both because of his extensive study of the subject and his re-evaluation of the Relative Value Index of the District of Columbia, which adopted this plan last year.

DIABETES DETECTION DRIVE

Approximately 2,000 finger blood tests were administered to Essex County residents at our two diabetes testing stations last November. We used Clinitron® machines and the "positives" were followed up by their family physician. This public testing program was highly successful due to the wonderful community cooperation shown by such groups as the Newark and East Orange Department of Health and the State Department of Health. Dr. Otto Brandman, our chairman, was responsible for setting up the two Clinitron® testing stations.

PUBLIC RELATIONS

Our Public Relations Committee, under the chairmanship of Dr. William Greifinger, produced some very fine results. The press gave fine coverage to our meetings and activities and we received nationwide coverage on two of our projects, the Essex County Health Fair and our Future Physicians Clubs.

HEALTH FAIR

Our Society, together with the Interprofessional Health Council of Essex County, sponsored an Essex County Health Fair in May 1960. Because of the combined efforts of our local health agencies, we were able to display 87 booths and reach 23,822 interested citizens. It was wonderful to participate in such community spirit and I personally believe the publicity given to the Health Fair was wonderful for the profession.

FUTURE PHYSICIANS CLUB

During my term as president, Dr. S. William Kalb, chairman of our Future Physicians

Club has developed this program so that it is the largest one in the country. We now have active clubs in thirty-eight Essex County High Schools and each club has two physician advisors. We have taken the clubs on field trips to medical schools, brought students to hospitals to witness medical procedures and to assist in hospital work. We have given first aid courses to interested high school students and our physicians have spoken to them at many meetings throughout the county. We have shown twelve AMA films on the future of medicine and various medical subjects to our student groups. We are now arranging for a mass meeting with the seniors of our Future Physician Clubs and their parents to discuss the prerequisites for college and medical schools and the economics involved in the pursuit of a medical course. Our Society has assumed the added responsibility of attempting to recruit talented and dedicated students for medical careers. We hope to assume leadership in maintaining a continuing quality in the ranks of physicians. We have planned programs which will stimulate an interest in our profession and expose the student to as much medicine as we can. In this way, we hope that he or she will have a well motivated desire to select a premedical course in college and go on to medical school. The AMA *News*, *Medical World News*, and *Medical Economics* all carried fine articles commending our club's activities. We have had letters from the deans of many medical schools favoring our program. Forty county medical societies throughout the country asked us how to start such a club.

Dr. Harvey P. Einhorn, chairman of our Speakers' Bureau, reported that he has sent out over 250 speakers to the public since last May. This is a fine job in bringing correct medical information to the public.

Our Society donated $2,500 to the Essex County Blood Bank to help equip their new building and $1,500 to Chr-Ill Service, an organization which serves the chronically ill and is sponsored by our Society.

Our Executive Secretary, Mr. Arthur Ellenberger, has been extremely helpful in implementing our programs, and securing good public relations for our Society.

Salem

Ford C. Spangler, M.D., President, Salem

The Salem County Medical Society has met the third Friday of each month from September 1960, at the DuPont Penns Grove Country Club, Carney's Point.

At the September meeting Dr. Carl Ware, the next President-Elect of The Medical Society of New Jersey, informed us of current and future state activities for the coming year.

The October meeting was devoted to a scientific discussion of psychiatric therapy, and the November meeting, to genetics.

Automotive safety was discussed by Dr. William Sprout during December.

The Salem County Bar Association had a joint meeting with us in January, with a forum consisting of two physicians and two lawyers acting as a panel for a question and answer session. We are sure this will be helpful in improving doctor-lawyer relationships.

Dr. William Dock, Professor of Medicine of the New York State University was our honored speaker in February. He was sponsored by the Salem County Heart Association.

Our last meeting in March was devoted to the nominations and appointments of our elected officers and committee members.

The approval of Dr. Sanford Rogg to head the Salem County Guidance Center has been a step forward to meet the health needs in our county. The Center has been supported by both county funds and the Community Mental Health Service Act. We have accepted two new Associate members, and we are hoping that the Society will, at the next meeting, vote passage of an amendment to our By-Laws to accept Courtesy members without voting privileges.

Union

Carl G. Kapp, M.D., President, Elizabeth

It was a privilege on the last night of our season to have the President of The Medical Society of New Jersey, Dr. Jesse McCall, address the members. Mr. Richard I. Nevin, the Executive Officer, who was also present, spoke on legislation.

The Program Committee presented fine speakers. One of the outstanding ones was Dr. Kenneth B. Babcock, Director of the Joint Commission on Accreditation of Hospitals.

The Blood Bank Committee has continued its important project. The Union County Blood Bank System is now functioning smoothly. The Elizabethtown Chapter of the American Red Cross will participate in the Red Cross New York Regional Blood Program and the Union County Medical Society has approved this. It will provide a blood mobile unit that will come into the area to supplement the blood needed at the local hospitals.

Last fall we had a fine day of golf followed by a dinner at the Plainfield Country Club.

One of the prime projects of the Public Relations Committee was distribution through some of the schools of cards about our Emergency Medical and Referral Services. Children, taking home the cards, bring to the attention of parents the services and the hope that some day every family will have a family physician; although it is also realized that there will always be some emergency calls. The cards can be posted near the home telephone.

Membership continues to grow. This year 14 physicians were elected to Active membership and 26 to Associate membership. Elected to Emeritus membership were: Dr. R. P. Blythe of Cranford, Dr. George W. H. Horre of Elizabeth, Dr. Grace Robertson Perrin of Plainfield and Dr. John E. Runnells of Scotch Plains. We regret to report the deaths of eight of our members of whom several were veterans of World War II.

The Medical Insurance Committee has had a busy year. The chairman has kept us all informed of latest developments in the professional liability insurance program approved by The Medical Society of New Jersey. Mr. Britton of the American Mutual Liability Insurance Company has been helpful to the Committee and to the executive staff in making the new change with little inconvenience.

The Judicial Committee has had few complaints to act upon; but the many applications for membership must be carefully checked and the status of Associate members reviewed often. If a member is not fulfilling the requirements for Active membership he is reminded of his duties.

Although the Constitution was revised in 1950, the Committee on Constitution and By-Laws constantly reviews it and proposed amendments when considered necessary so that the Society may properly function in all departments.

The Indoctrination Committee is one of the busiest in the Society. It has held two meetings in the homes of members of The Woman's Auxiliary. The young physicians just starting out in practice are informed of their duties as Associate members, of ways to avoid certain problems, of the importance of good public relations, particularly with their patients and patients they see for, or with, other physicians. Attendance at these meetings is almost one hundred per cent and the collation served afterward makes a pleasant social hour.

The Woman's Auxiliary has been ever ready to assist the Society in all projects when called upon and we are deeply appreciative.

The Union County Medical Assistants Society grows in numbers and in interest. The organization is now four years old and their enthusiasm is as great as at the start of their program. It is a fine group and we are well aware of the good public relations they render the medical profession.

The Workmen's Compensation Committee held several satisfactory meetings at which problems were settled as the members and representatives of the insurance companies were both willing to work together to adjust all problems.

The Advisory Committee to the Visiting Nurse Association of Eastern Union County met with the group. Their director was most appreciative that the chairman of our committee appeared with her before Elizabeth officials regarding nursing services in the area.

Due to an inquiry by an interested professional group, the Public Health Committee made a survey on the poliomyelitis inoculation program and found that the situation is good except in one municipality. The Committee has made certain recommendations and with the

cooperation of those who have offered assistance it is felt that this problem will be solved.

The Advisory Committee to the Medical-Surgical Plan keeps the members informed of all changes. They are always available whenever individual problems arise and are most helpful.

It would be impossible to enumerate the work done by all of the committees and members as everyone has contributed services when called upon. The Executive Office staff, Miss Rogers and Mrs. Fitzgerald have carried out the routine work of the office and assisted the members whenever called upon. It has been, as always every year, a busy one but also stimulating. The new officers will complete projects started this past season and will no doubt have new ones to work on during the coming year.

Warren

Neumann C. Marlett, M.D., President, Belvidere

The members of the Warren County Medical Society continued to turn out in good numbers for our meetings in 1960. At one session we viewed the film, "No Margin for Error." At another meeting Dr. Ellen I. Simon, Medical Director of the Warren County Guidance Center, spoke on the workings of the clinic. At another meeting we heard from Dr. Roscoe P. Kandle, Commissioner of Health, who spoke on viral diseases. He told us of steps we could take in suspected outbreaks and he outlined some of the interesting epidemiologic problems in the recent outbreak of eastern encephalitis.

During the year some new names appeared on our rolls. Dr. Edward L. Minier of Hackettstown, was elected as an Associate member. A transfer of Dr. James A. Harps from the Hunterdon County Medical Society to our Society was effected. Dr. Ellen I. Simon was accepted as a "courtesy member," after it was determined that she was in good standing in New York State. Dr. Enrique J. Gavilondo was elected into Associate membership.

Some of the problems brought to the attention of the members during the year were as follows:

1. The potentially undesirable features of sending specimens to distant laboratories which do great volumes of work at low monthly rates. A letter outlining the dangers, composed by Dr. Paul deR. Kolish, was spread upon our minutes.

2. We discussed the problem of foreign physicians on our house staffs who did not pass the E.C.F.M.G. examination. We went on record as favoring easier grading and for extending the deadline for acceptance, thus giving hospitals more time for adjustment.

3. The inadequacy of the Medical Student Loan Fund to cover all requests. We allocated monies to the fund.

In April 1960 we co-sponsored a series of lectures and had a good turn-out. The series was as follows:

April 6, 1960: "Rehabilitation of the Patient with Paraplegia"—Henry H. Kessler, M.D., Medical Director, Kessler Institute for Rehabilitation.

April 13, 1960: "Treatment of Chronic Arthritis"—John Lansbury, M.D., Professor of Clinical Medicine, Temple University.

April 20, 1960: "Treatment of Inoperable or Terminal Cancer"—George T. Pack, M.D., Professor of Clinical Surgery, New York Medical College.

April 27, 1960: "Chronic Skin Disorders"—Bernard A. Kirshbaum, M.D., Instructor in Dermatology, University of Pennsylvania.

As usual, our Christmas party was a gala event, with 39 couples partaking of delicious food, enjoying good companionship, and engaging in lusty carol singing, under the leadership of Dr. John Raymond of Lafayette College.

We look forward with great pride to May 1961 when the presidency of the Medical Society is assumed by our own Dr. Ralph M. L. Buchanan. Through the years he has worked long and hard in medical society matters, and we are confident his experience and wisdom will carry The Medical Society of New Jersey further toward its goals.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

APRIL, 1961 • VOL. XXXIV, No. 4

EXPERIMENTAL EFFECT OF CIGARETTE SMOKE ON HUMAN RESPIRATORY CILIA

The mechanism of the efficient housekeepers of the lower respiratory tract and the nose, the cilia, is interfered with by the smoke from a cigarette, as illustrated in the experiment described. The slackened efficiency of the cilia appears related to the cough of smokers.

The purpose of the experimental work reported in this manuscript is to demonstrate a possible mechanism whereby tar and other combustion products in cigarette smoke might be deposited in the lower respiratory tract of human beings. An impressive body of literature has accumulated to support the thesis that prolonged heavy cigarette smoking is positively related to the increased incidence of bronchogenic carcinoma.

If the combustion products in tobacco smoke contain carcinogenic tars (or arsenic), how does this substance collect in the bronchi and remain sufficiently long to induce a carcinoma? Normally, the respiratory cilia are most efficient in keeping the nose and the bronchial air tubes clean. The cilia of the lower respiratory tract are in constant motion, day and night, sweeping the overlying blanket of mucus toward the upper end of the esophagus. In the nose, the action of the cilia moves the mucous blanket posteriorly to the pharynx.

Failure of the cilia to beat efficiently brings about a stasis of the blanket of mucus and permits injurious material contained in the mucous blanket to remain in contact with the bronchial or nasal surfaces. In health the continuous beat of the cilia is the principal mechanism whereby the posterior two thirds of the nose and the entire lower respiratory tract keep themselves clean.

JOHN J. BALLENGER, M.D., *The New England Journal of Medicine*, October 27, 1960.

MEASURING CILIARY ACTIVITY

The question arose whether or not there was some substance in cigarette smoke that caused a stasis of the ciliary cleansing mechanism. Experimental setups designed to measure the effects of various substances on ciliary activity have always lacked an accurate criterion to measure this activity. The ciliated cells must constantly be bathed in physiologic wetness. Dryness rapidly injures the cilia and destroys the accuracy of measurement. Whatever method is used must accurately provide for humidity control. An attempt to measure ciliary activity in the isolated epithelial strip and in vivo was greatly hampered by this factor.

In the method used by me, minute bits of epithelium taken from the trachea and bronchi of humans are placed in a clot (equal parts of chick embryo extract and chicken plasma) which is adherent to a cover slip. When properly made, the cilia can be seen through the microscope to be beating furiously and will continue beating for two weeks or longer with no further attention. At any time the cover slip and clot may be transferred to a perfusion chamber; the experimental solution may be perfused, and the effect on the cilia observed and recorded on moving-picture film.

Sometimes immediately and sometimes some hours later, aggregates of ciliated cells can be seen through the microscope to have become detached from the main explant to form an

irregular rounded mass with the cilia outward. The furiously beating cilia cause the separate aggregate of cells to rotate 6 to 30 times per minute. The rotation serves as a convenient quantitative criterion of ciliary activity.

CIGARETTES MECHANICALLY SMOKED

The clot containing the rotating groups of cells is first bathed in the basic salt solution, and the speed of rotation of the particular explant selected for experimentation is observed and recorded on moving-picture film exposed at 16 frames per second. A "baseline" rotation speed is thus obtained. Next, perfusion is carried out with the test solution, and the effect on the speed of rotation observed and recorded on moving-picture film exposed at 16 frames per second. A quantitative comparison can thus readily be made between the baseline observations and those after perfusion with the test solution.

The test solution for these experiments was prepared as follows. Two "regular"-sized cigarettes were mechanically "smoked" by intermittent drawing of room air through the cigarettes at a rate of 1 liter per minute. Approximately one and a half to two minutes were required to "smoke" each cigarette. The smoke was allowed to escape under the surface of 100 ml. of the basic salt solution. A sintered glass filter was used to insure good contact of the smoke and the solution. Glass-wool filters were inserted in two locations to prevent gross particulate tobacco from reaching the basic salt solution. In successive experiments cigarettes, both with and without "filters," were used.

The basic salt solution changed from colorless to slightly amber. In the solutions tested, the pH dropped from approximately 7.76 to 7.38. All solutions used were at room temperature.

Perfusion with the basic salt solution alone caused no appreciable change in the rotation of the aggregates of ciliated cells. If left undisturbed, rotation would have lasted for 36 to 48 hours.

Perfusion with the "smoked" basic salt solution stopped rotation within five to 28 minutes in 12 consecutive experiments. In some cases if the exposure to the "smoked" basic salt solution was terminated before the toxic effect was marked, return to the baseline speed of rotation could be produced by reperfusion with salt solution alone.

EFFECT OF TAR

It is known that tar from cigarette smoke painted on the skin of a mouse for a third to a half the lifetime of the animal can induce skin carcinoma. It seems reasonable to assume that a similar development could occur on the bronchial mucosa of man if the tar (or other carcinogens) are in contact with the same part of the mucosa for a sufficiently long time. The present experiments demonstrate how the human ciliary mechanism fails in vitro when exposed to smoke in solution from as few as two cigarettes. The failure of the ciliary mechanism was irreversible if great care was not taken very soon to remove the "smoked" basic salt solution. It is suggested that this is one of the mechanisms whereby tars may collect in the lower respiratory tract and come into contact with the mucosa.

If the person concerned is a heavy and persistent smoker, the tars may be assumed to stay in contact with the bronchial mucosa for longer periods. Further experimental work is currently going on to determine if combustion products of petroleum, factory gaseous wastes, and so forth, have similarly deleterious effects on the cilia.

It seems likely that the decreased efficiency of the ciliary mechanism caused by smoke plays a part in the productive cough noted by smokers. If the cilia do not keep the airway clean, the blanket of mucus containing foreign material collects and eventually initiates the cough reflex.

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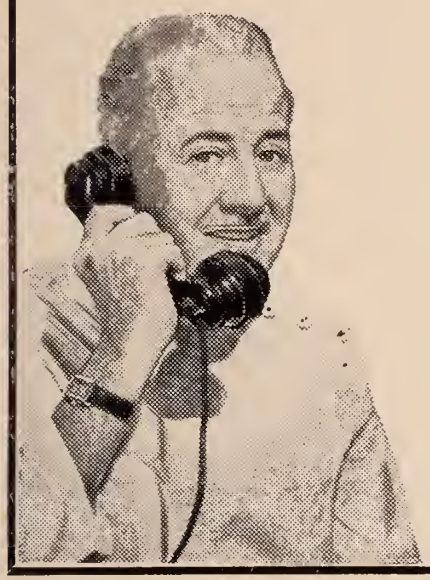
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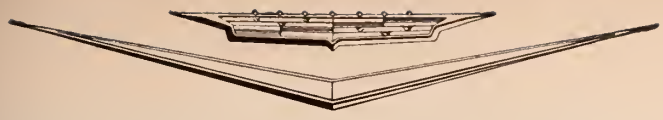
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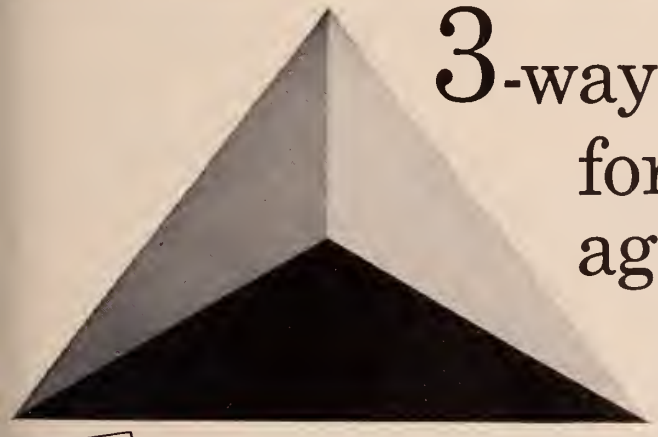
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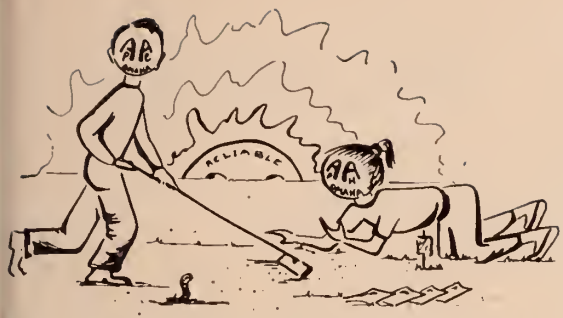
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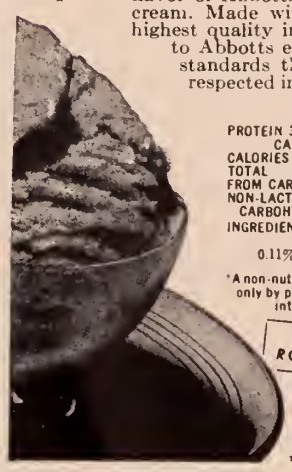
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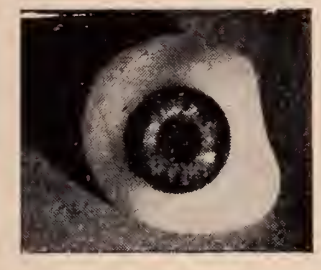
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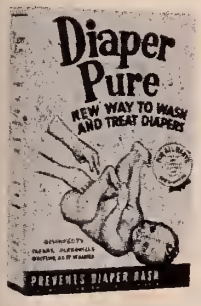
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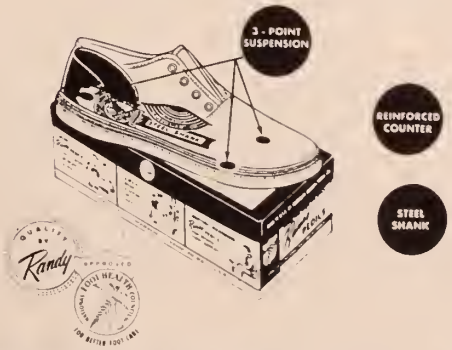
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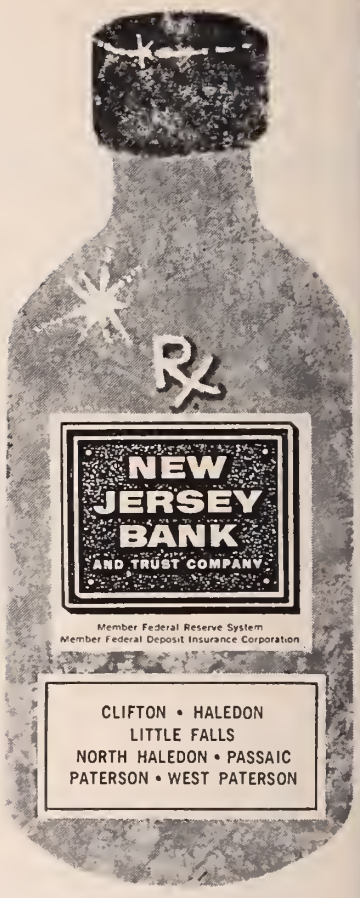
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OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 58, No. 5 MAY, 1961 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

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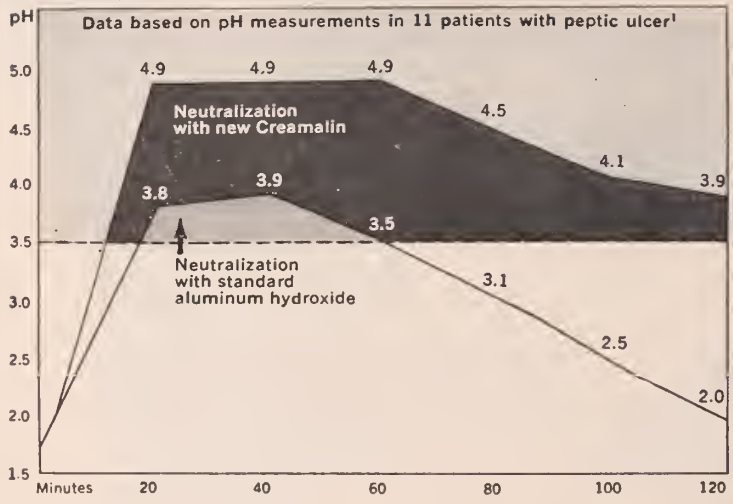
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Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

1467M

Proven

in over six years of clinical use and
more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

1 simple dosage schedule produces rapid, dependable tranquilization without unpredictable excitation

2 no cumulative effects, thus no need for difficult dosage readjustments

3 does not produce ataxia, change in appetite or libido

4 does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis

5 does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; in bottles of 50.

Also supplied in sustained-release capsules . . .

Meprospan®

Available as Meprospan-400 (blue-topped *sustained-release* capsules containing 400 mg. meprobamate), and Meprospan-200 (yellow-topped *sustained-release* capsules containing 200 mg. meprobamate).

CM-4238

WALLACE LABORATORIES / *Cranbury, N. J.*



. . . time after time, Patrician "200" guarantees x-ray exposures exactly as you dial them

In periodic patient follow-up, you really come to appreciate the meaning of "True-to-Dial" accuracy with the G-E Patrician "200" combination. Film comparison is easier because of guaranteed consistent x-ray output. Performance holds predictably from range to range . . . even from one G-E unit to another! And with it you get so many more Patrician features: full-size 81" tilting table . . . independent tubestand . . . counterbalanced, not counterpoised, fluoroscopic screen or spot-film device . . . radiation confined to screen area by automatic shutter limiting device . . . economy of purchase and operation.

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you can't prescribe a more effective antibiotic than ERYTHROCIN®

Erythromycin, Abbott

How much "spectrum" do you need in treating an infection? Clearly, you want an antibiotic that will show the greatest activity against the offending organism, *and the least activity against non-pathogenic gastro-intestinal flora.*

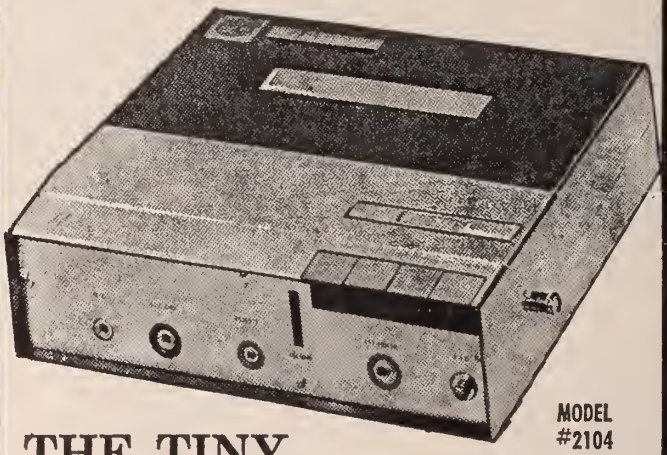
Weigh these criteria—and make this comparison—when treating your next coccal infection. Erythrocin is a medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections—*which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

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THE TINY TAPE RECORDER WITH THE BIG PERFORMANCE!

So small it fits in the smallest briefcase with plenty of room left over! Wonderful for office, school or home, perfect as a gift that keeps on giving! Only 4½ pounds, 8" x 8" x 2½". Battery powered. Push Button controls. Two constant speeds, dual track; records and plays back one full hour on a 3" reel of tape. With mike, batteries and carrying strap. Gift Boxed.

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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

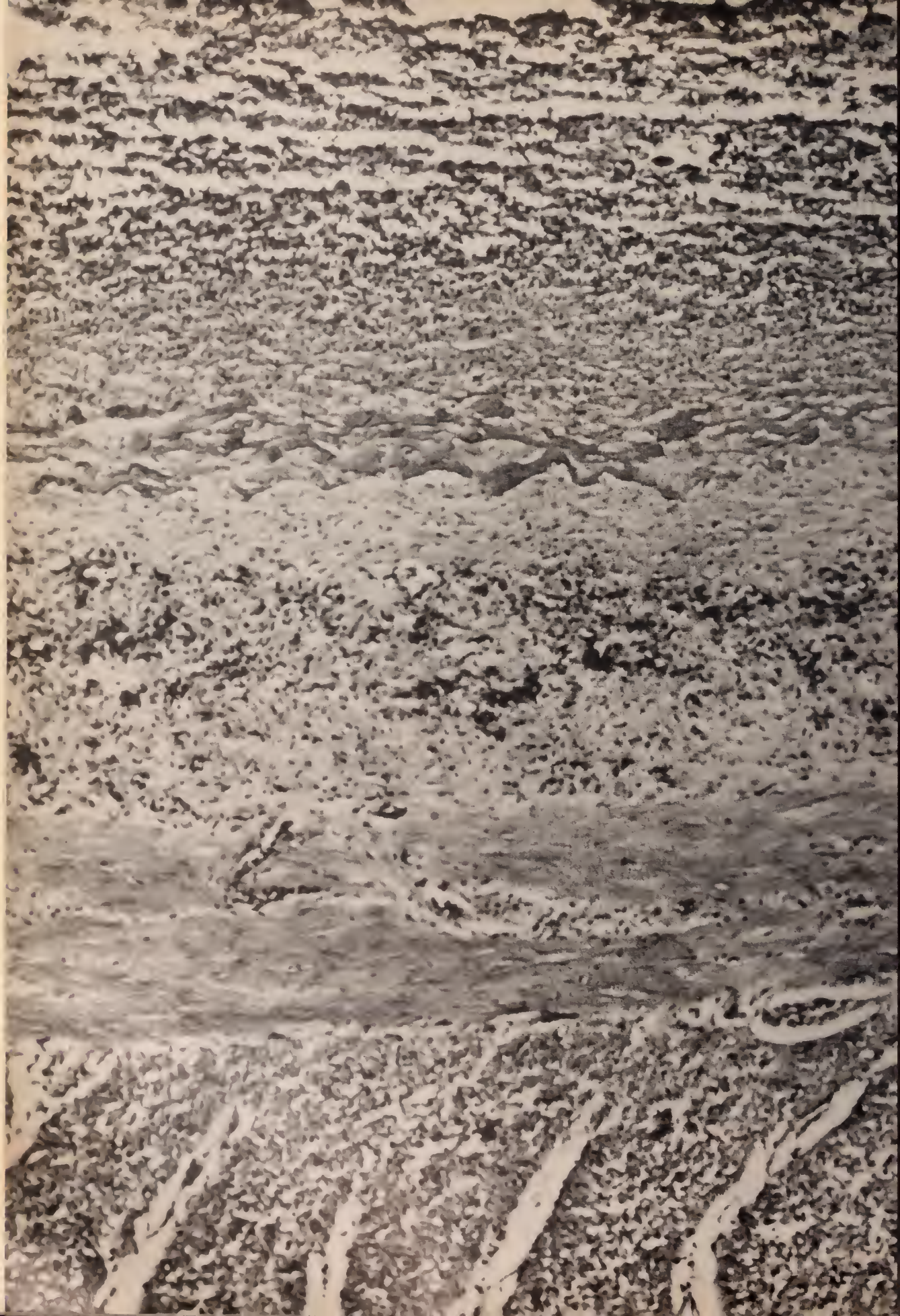
Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET T.I.D.

muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey





Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including ubiquitous staphylococci. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Adult dosage: 2 capsules four times a day.

Side effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.

Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests.

Urticaria and maculopapular dermatitis, a few cases of leukopenia, and agranulocytosis have been reported in patients treated with Albamycin. All of these side effects rapidly disappeared upon discontinuance of the drug.

Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.

As with any serious infection, therapy of peritonitis with Panalba or other antibacterial agents is adjunctive to surgical procedures and supportive therapy.

Inflammatory process of the peritoneum

The Upjohn Company
Kalamazoo, Michigan

Upjohn

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*Trademark, Reg. U. S. Pat. Off.

Panalba*

your broad-spectrum

Acts within minutes—KOAGAMIN, unlike other hemostatic agents, acts *quickly* in *minimal* dosages. Working on the late phases of the clotting mechanism, KOAGAMIN does not require massive and prolonged pre- or postoperative dosages to control capillary and venous bleeding.

Acts with predictable safety—In 20 years of clinical use, no toxic or side actions have been reported with KOAGAMIN. Bleeding is arrested without danger of thrombosis, and because KOAGAMIN contains no protein or alkaloid, it can be administered without danger of sensitization or untoward reactions.

Acts effectively in a broad range of indications—Because of its *unparalleled safety* and *outstanding effectiveness,* KOAGAMIN has been successfully employed in...hemorrhagic diseases, abnormal bleeding, blood disorders, surgical cases and trauma.

KOAGAMIN, an aqueous solution of oxalic (5 mg. per cc.) and malonic (2.5 mg. per cc.) acids for parenteral use, is supplied in 10-cc. diaphragm-stoppered vials.

CHATHAM PHARMACEUTICALS, INC • NEWARK 2, NEW JERSEY
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Chatham

BEFORE, DURING AND AFTER SURGERY

KOAGAMIN®

(parenteral hemostat)

controls bleeding with minimal dosage and maximum safety

10360

how would you design a tranquilizer specifically for children?



wouldn't you want it to be:	see how closely these ATARAX advantages meet your standards:
efficacious	"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior. . . ."[1]
remarkably well tolerated	"The investigators were impressed with the lack of toxicity and minimal side effects which were observed even after long-term use."[2]
palatable	Delicious ATARAX syrup pleases even the balkiest patient.

Nor is that all ATARAX has to offer. In the allergic child, ATARAX offers added antihistaminic action to help control asthma and urticaria.[3] In fact, though outstandingly useful in children,[1-4] ATARAX equally well meets the needs of the elderly, and of the tense working adult (it calms, seldom impairing mental acuity). Why not extend its benefits to *all* your tense and anxious patients?

Dosage: For children: under 6 years, 50 mg. daily; over 6 years, 50-100 mg. daily; in divided doses. For adults: 25 mg. t.i.d. to 100 mg. q.i.d. *Supplied:* Tablets 10 mg. and 25 mg., in bottles of 100 and 500. Tablets 100 mg., in bottles of 100. Syrup, 2 mg. per cc., in pint bottles. Also available: Parenteral Solution. Prescription only.

References: 1. Freedman, A. M.: Pediat. Clin. North America *5*:573 (Aug.) 1958. 2. Nathan, L. A., and Andelman, M. B.: Illinois M. J. *112*:171 (Oct.) 1957. 3. Santos, I. M. H., and Unger, L.: Ann. Allergy *18*:179 (Feb.) 1960. 4. Litchfield. H. R.: New York J. Med. *60*:518 (Feb. 15) 1960.

ATARAX®

PASSPORT TO TRANQUILITY

(brand of hydroxyzine)

Roerig Rx

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®

VITERRA® Capsules—Tastitabs®
—Therapeutic Capsules for
vitamin-mineral supplementation



effective, palatable, economical

CREMOSUXIDINE®[SULFASUXIDINE® SUCCINYLSULFATHIAZOLE SUSPENSION WITH KAOLIN AND PECTIN] reduces fluidity of stools, reduces enteric bacteria, adsorbs toxins, and soothes the irritated intestinal mucosa.

Chocolate-mint flavored...readily accepted by patients of all ages.

Additional information on CREMOSUXIDINE is available to physicians on request.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., WEST POINT, PA.

CREMOSUXIDINE AND SULFASUXIDINE ARE TRADEMARKS OF MERCK & CO., INC.

Percodan tablets effectively relieve pain through a range of



intensities commencing with moderate pain and extending



through major traumatic areas into further regions of severe pain



Percodan®

(Salts of Dihydrohydroxycodeinone and Homatropine, plus APC)

TABLETS

for pain

prompt relief
profound relief
prolonged relief

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. acetophenetidin, and 32 mg. caffeine.

Also available—for greater flexibility in dosage—PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

LITERATURE AVAILABLE ON REQUEST

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Patent Nos. 2,628,185 and 2,907,768

Now—From the makers of Fleischmann's Margarine comes the...

Only Unsalted Margarine Made from 100% Corn Oil!

- ✳ Wonderful for sodium-restricted diets—10 mgs. of sodium per 100 grams!
- ✳ Contains liquid corn oil and partially hydrogenated corn oil!
- ✳ Delicious flavor like the sweet, high-price spread!
- ✳ Fresh-Frozen—available only in grocers' frozen food cases!



Now, Fleischmann's announces a new unsalted margarine for patients on low-sodium diets, and for those who simply prefer the sweet taste of an unsalted spread. It's new Fleischmann's Sweet (Unsalted) Margarine, made from 100% corn oil. This new margarine has a linoleic acid content higher than any other margarine available at grocery stores . . . and ten times higher than the high-price spread. Thirty percent (30%) of the fat in Fleischmann's is polyunsaturated.

Smooth, Fresh Flavor Preserved By Exclusive Fresh-Frozen Process

This new unsalted margarine has a light, fresh flavor your patients will find delicious. And because it contains no salt or other preservatives, it's Fresh-Frozen for flavor protection. Your patients can be sure it's always fresh and pure.

Although this new margarine is Fresh-Frozen, the quarter in use may be kept in the refrigerator as any other spread. The remaining quarters should be stored in the freezer.

For Patients On Sodium-Restricted Diets

If your patients need sodium restriction, recommend delicious new Fleischmann's Sweet (Unsalted) Margarine. It's ideal as a table spread and for cooking. It comes in a *bright green* foil package and is found in the grocer's frozen food case. Remember Fleischmann's is the first and only unsalted margarine made from 100% corn oil.



By the Makers of Fleischmann's Yeast

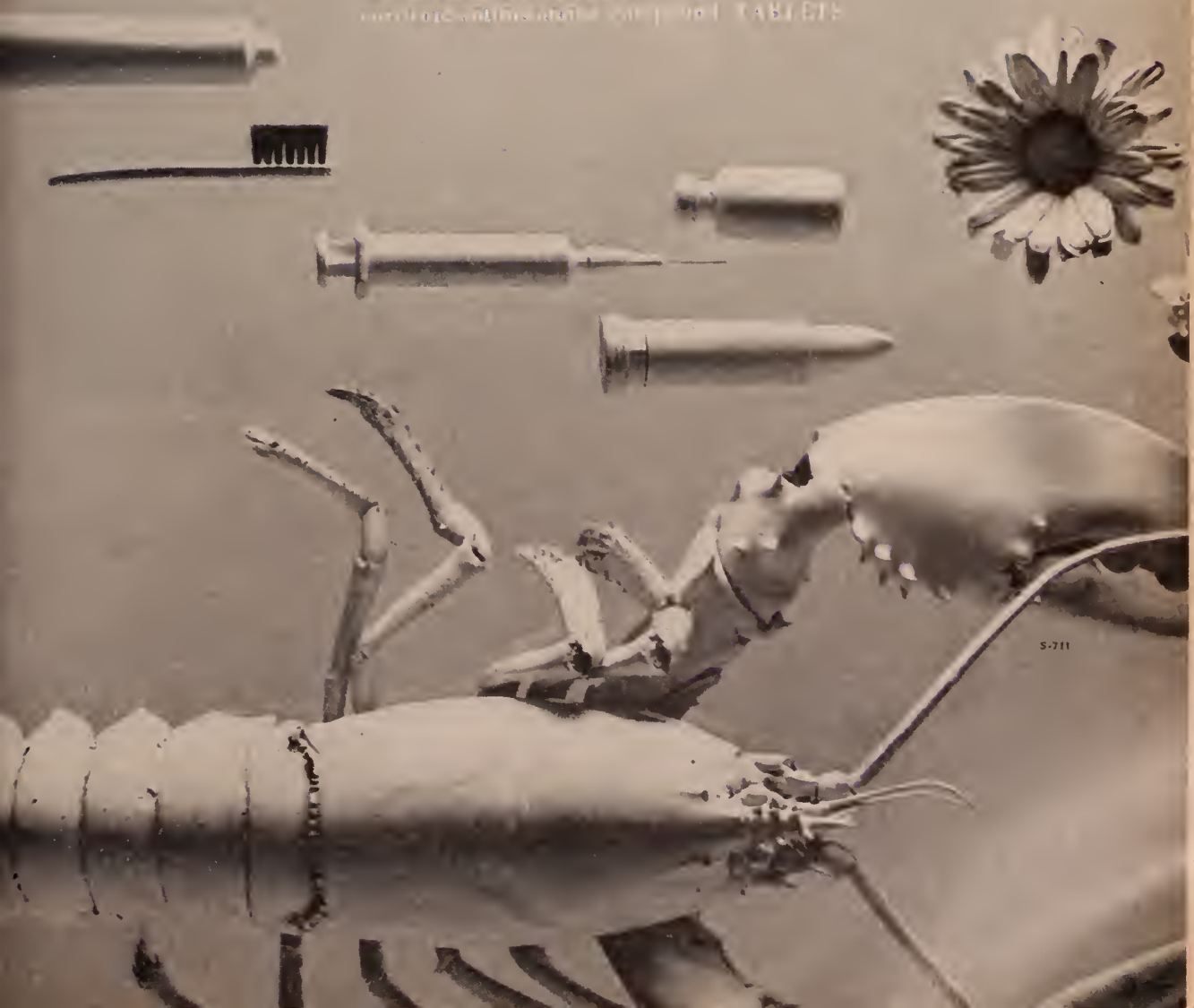
Fleischmann's *SWEET (UNSALTED) MARGARINE*

Made from 100% CORN OIL

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for allergies that are "out of control"

METRETON®





Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing.

Rautrax-N offers all the advantages of Raudixin, Naturetin and potassium chloride in a single dosage form *plus: increased efficacy* – Combined action of Raudixin and Naturetin results in a potentiated antihypertensive effect greater than that produced by either drug alone. *increased safety* – Potentiated action permits lower dose of other antihypertensive agents, thus reducing severity of side effects. Protection against possible potassium depletion. *flexibility* – Interchangeable with either Raudixin or Naturetin & K. *economy* – Maintenance dosage of only 1 or 2 tablets daily for most patients. *convenience* – Once-a-day maintenance dosage. Two potencies available.

Supply: Rautrax-N – capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* – capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

Rautrax-N*

For full information, see your Squibb Product Reference or Product Brief.

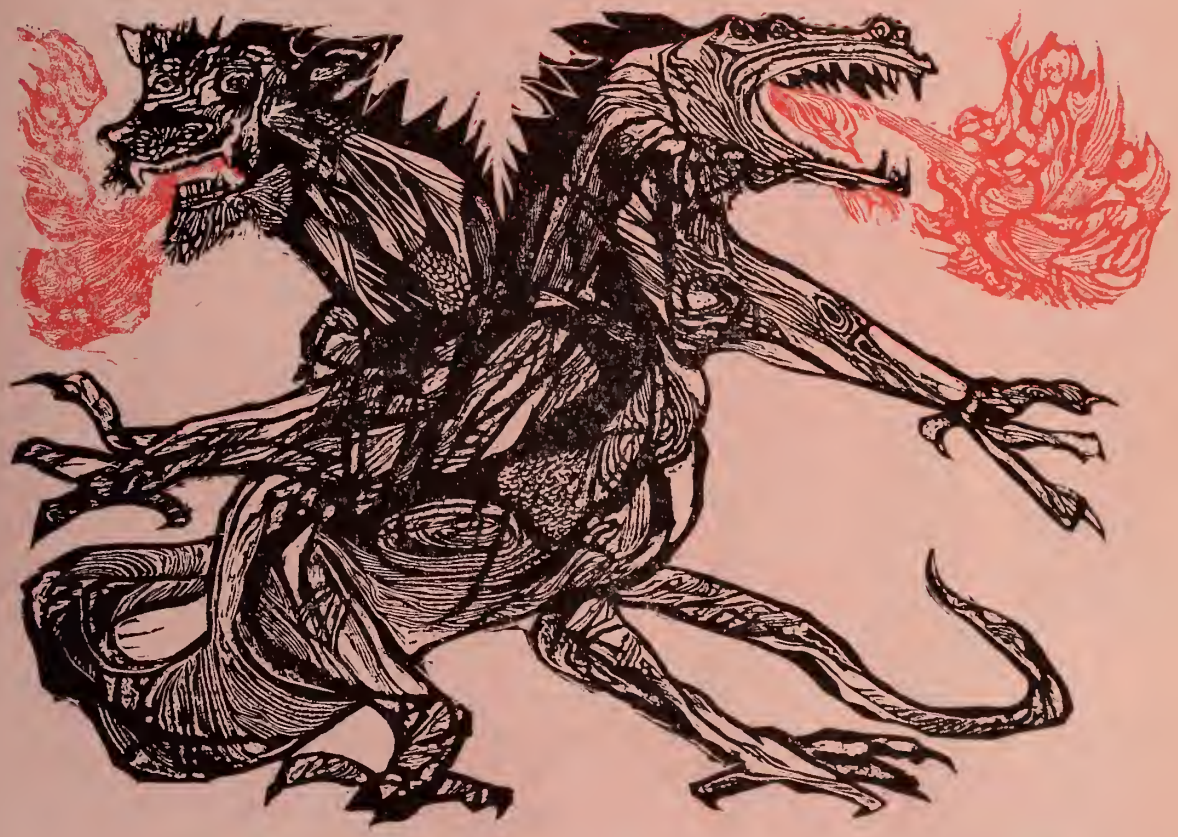
Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Bendroflumethiazide (*Naturetin) with Potassium Chloride

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Squibb Quality – the Priceless Ingredient

'RAUDIXIN'®, 'RAUTRAX'® AND 'NATURETIN'® ARE SQUIBB TRADEMARKS

When severe pain accompanies skeletal muscle spasm ease both 'pain & spasm'



with **Robaxisal**®

ROBAXIN® with Aspirin

A dual-acting skeletal muscle relaxant-analgesic, combining the clinically proven relaxant action of ROBAXIN with the time-tested pain relieving action of aspirin.

Each ROBAXISAL Tablet contains:
ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid (5 gr.)..... 325 mg.
U.S. Pat. No. 2770649
Supply: Bottles of 100 and 500 pink-and-white laminated tablets.

Or ROBAXISAL®-PH (ROBAXIN with Phenaphen®) — when anxiety is associated with painful skeletal muscle spasm.

Each ROBAXISAL-PH Tablet contains:
ROBAXIN (methocarbamol Robins) 400 mg. Acetylsalicylic acid ..... 81 mg.
Phenacetin 97 mg. Hyoscyamine sulfate 0.016 mg. Phenobarbital (1/8 gr.) 8.1 mg.
Supply: Bottles of 100 and 500 green-and-white laminated tablets.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity... seeking tomorrow's with persistence.


unsurpassed "general-purpose" steroid outstanding for "special-purpose" therap
Aristocort®

in allergic respiratory disorders

Aristocort®

Triamcinolone LEDERLE

UNSURPASSED "GENERAL-PURPOSE" STEROID
OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in treating allergic respiratory disorders, including bronchial asthma. Clinical evidence has now shown that ARISTOCORT is also highly valuable for "special-problem" patients—asthmatic and others—who, because of certain complications, were hitherto considered poor candidates for corticosteroids.

for example:

PATIENTS WITH IMPENDING CARDIAC DECOMPENSATION

In contrast to most of its congeners, ARISTOCORT is not contraindicated when edema is present or when cardiac decompensation impends.[1]

PATIENTS WITH EMOTIONAL AND NERVOUS DISORDERS

Triamcinolone did not produce psychic disturbances or insomnia.[2]

PATIENTS WHOSE APPETITES SHOULD NOT BE STIMULATED

Among patients treated with ARISTOCORT, there was less appetite stimulation, especially in those who had previously gained weight on long-term therapy with other steroids.[3]

PATIENTS WITH HYPERTENSION

There was no blood pressure increase in any patient treated for bronchial asthma, and in some, blood pressure fell. Of these, three had been hypertensive.[4]

References:

1. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.
2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959.
3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958.
4. Sherwood, H., and Cooke, R. A.: *J. Allergy* 28:97 (March) 1957.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white). Also available—syrup, parenteral and various topical forms.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

derle

RLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

introducing a modern concept in nutrition...



Nutrament

BRAND

nutritionally complete food

a nutritious meal, ready to drink

to supplement inadequate diets...to replace skipped meals

Nutrament provides a scientifically balanced ratio of protein-fat-carbohydrate. Each 12½-ounce serving contains: 20 grams of quality protein; 50 grams of carbohydrate; and 13.3 grams fat, with added vitamins and minerals.

..nutritional support in convenient, tasty, liquid form

when time, habit, or circumstance interfere with good nutrition

Nutrament may be used by individuals who skip breakfast or lunch or do not eat properly because of busy schedules or faulty eating habits; and by those adolescents whose poor dietary selections fail to meet their nutritional needs so important during this period of active growth.[1]

when nutritional deficiencies threaten or require correction

Nutrament also is useful for obstetric patients who often require sound, easily tolerated, and convenient nutritional supplementation during pregnancy and lactation;[2] and for geriatric and other patients who cannot or will not maintain proper nutrition because of poor dentition,[3,4] faulty eating habits,[1,3] or lack of interest in eating.[3,5]

when oral, dental, or surgical problems prevent ingestion of solid food

Nutrament liquid, sipped directly from a glass or through a straw, may be used to provide good nutrition in patients who are unable to chew solid foods or in whom solids are contraindicated.

when hospital and convalescent diets require supplementation

Even though prescribed, adequate diets may not be consumed because of the difficulty of providing personalized nutritional supplementation and encouragement of feeding.[6] Nutrament is easily adjusted to the individual patient's needs; provides excellent nutritional support; requires no special preparation.

scientifically formulated to provide all known essential nutrients

Each 12½ fl. oz. can of Nutrament liquid provides 400 calories. Caloric Distribution: protein—20%; fat—30%; carbohydrate—50%; plus following vitamins and minerals:

		%MDR
Vitamin A (U.S.P. Units)	1250	30
Vitamin D (U.S.P. Units)	125	30
Vitamin C, mg.	50	166
Thiamine, mg.	0.5	50
Riboflavin, mg.	0.6	50
Niacinamide, mg.	5.0	50
Calcium, Gm.	0.5	67
Phosphorus, Gm.	0.4	53
Iron, mg.	4	40
Iodine, mcg.	60	60
Vitamin E (Int. Units)	2.5	
Pyridoxine, mg.	0.4	
Vitamin B_{12}, mcg.	0.5	
Calcium pantothenate, mg.	2.0	
Sodium, Gm.	0.2	
Potassium, Gm.	0.9	
Copper, mg.	0.5	
Manganese, mg.	1.0	
Fiber, Gm.	0.55	

ingredients

Whole milk, skim milk, sugar, soy flour, Dextri-Maltose,® (maltose and dextrins derived from enzymic action of choice barley malt on selected corn flour) starch, chondrus extract, sodium alginate, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, niacinamide, ferrous sulfate, sodium iodide, d-alpha-tocopheryl acetate, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, salt, cupric carbonate, manganese sulfate, cocoa and/or vanilla flavor.

readily accepted by patients

Nutrament liquid requires no special preparation. The smooth texture and appealing taste of Nutrament make it readily acceptable. Equally delicious served hot or cold. Nutrament also has a high satiety value.

supplied

In 12½-fluid-ounce cans, chocolate and vanilla flavors. Conveniently available at drug and food stores.

references

(1) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (2) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (3) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960. (4) Shaw, J. H., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, pp. 558-601. (5) Campbell, D. G.: *ibid*, pp. 888-910. (6) Abbott, W., in Allison, J. B.: Ann. New York Acad. Sc. *69*:1018-1022 (Jan. 10) 1958.

36261

Edward Dalton Co.
A DIVISION OF
MEAD JOHNSON & COMPANY

Quality products from nutritional research



He needs his muscles working properly—
when they aren't, he needs

Trancopal

How to use *Trancopal*®

Brand of chlormezanone

in musculoskeletal "splinting"

Although "splinting" of a joint by skeletal muscle spasm is often protective, it can go too far or continue too long. Then spasm, pain and disuse may lead to wasting.

When you prescribe Trancopal, you can prevent "oversplinting." Trancopal will relax the spasm, ease the pain and get the muscle working again. Relaxation generally begins within half an hour, and the effects of one tablet last from four to six hours.

In addition to relaxing the muscle, Trancopal will mildly tranquilize the patient, reducing the restlessness and irritability that so often accompany discomfort. With Trancopal, the patient can soon start purposeful exercise and physical therapy.

Trancopal has been found very effective in the treatment of patients with low back pain (lumbago), neck pain (torticollis), bursitis, fibrositis, myositis, ankle sprain, tennis elbow, osteoarthritis, rheumatoid arthritis, disc syndrome and postoperative muscle spasm. Trancopal is available in 200 mg. Caplets® (green colored, scored) and in 100 mg. Caplets (peach colored, scored), bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop LABORATORIES
New York 18, N.Y.

1591M



an added measure of protection for little patients

against relapse
against "problem" pathogens

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

pediatric drops
syrup

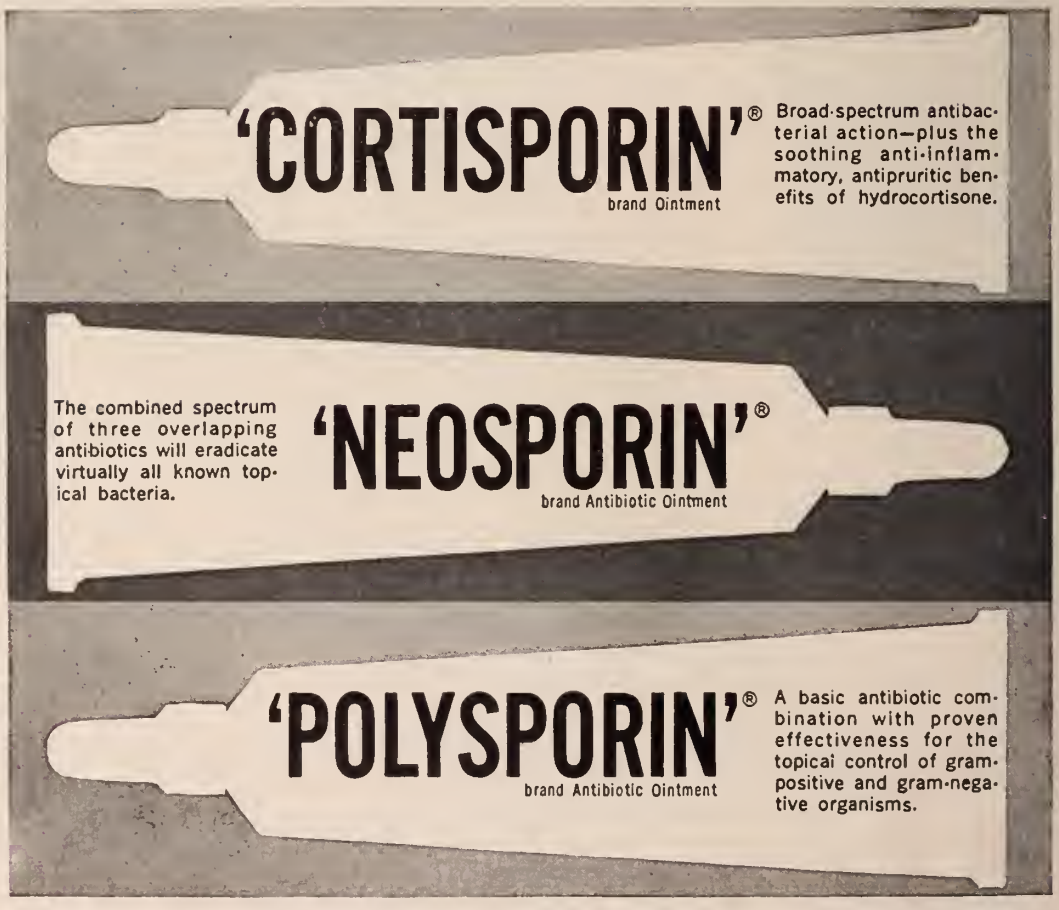
● full antibiotic activity ● lower milligram intake per dose ● up to 6 days' activity with 4 days' dosage ● uniformly high, sustained peak activity ■ **syrup** (cherry-flavored), 75 mg./5 cc. tsp., bottles of 2 and 16 fl. oz. Dosage: 3 to 6 mg./lb./day—in four divided doses. **pediatric drops,** 60 mg./cc., 3 mg./drop, 10 cc. bottles with calibrated dropper. Dosage: 1 to 2 drops/lb./day—in four divided doses.

PRECAUTIONS: As with many other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs discontinue medication. Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
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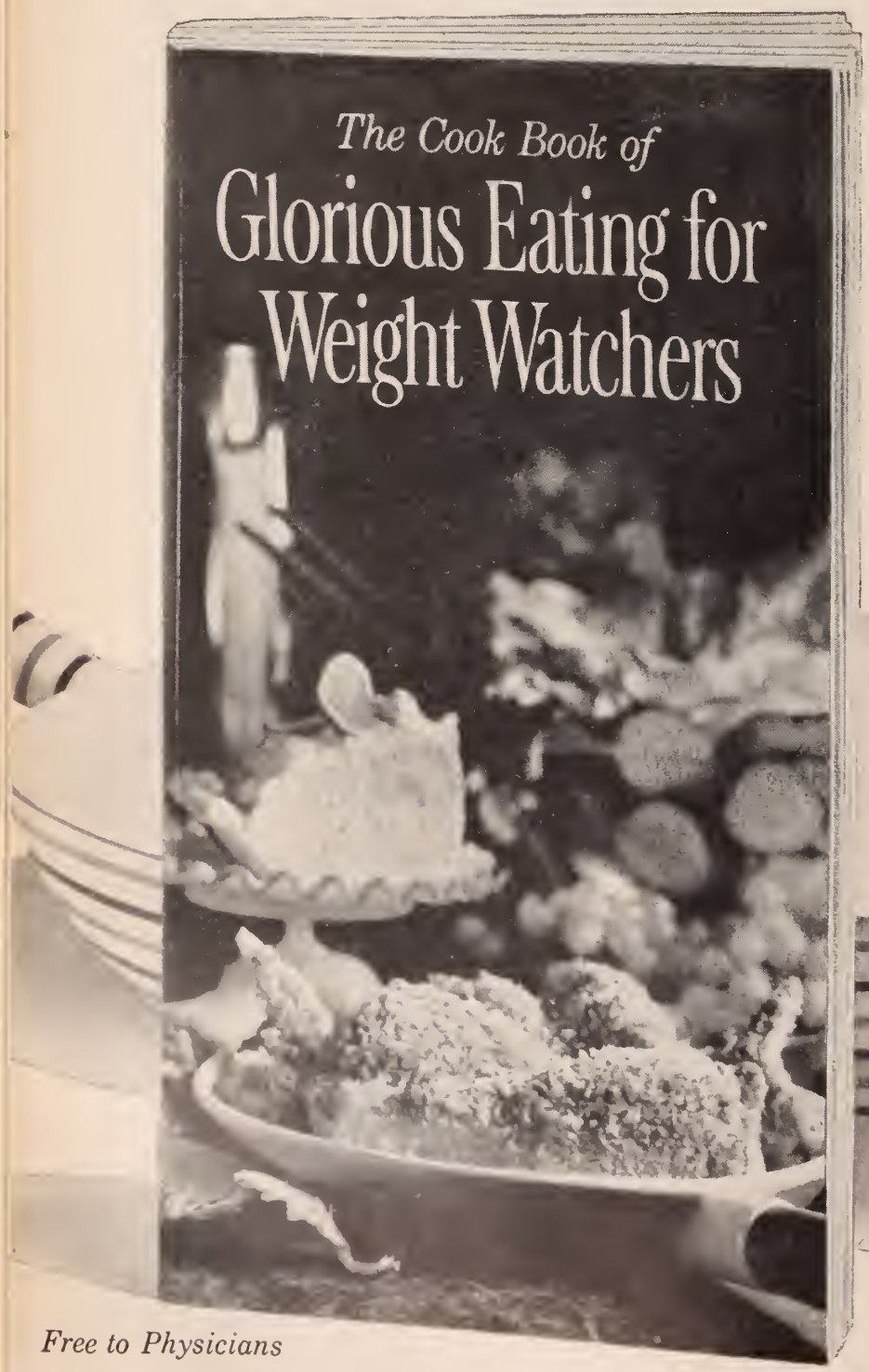
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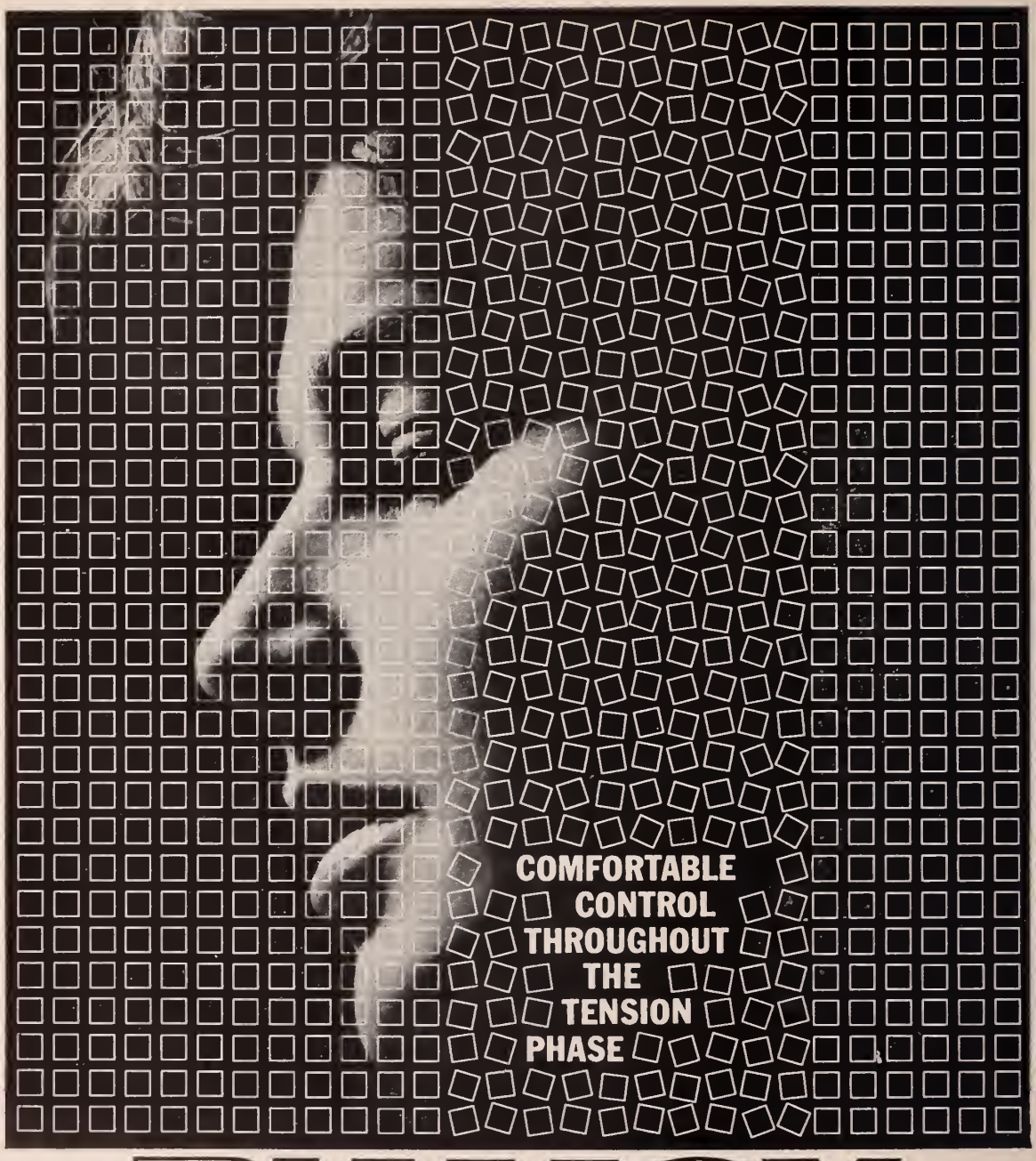
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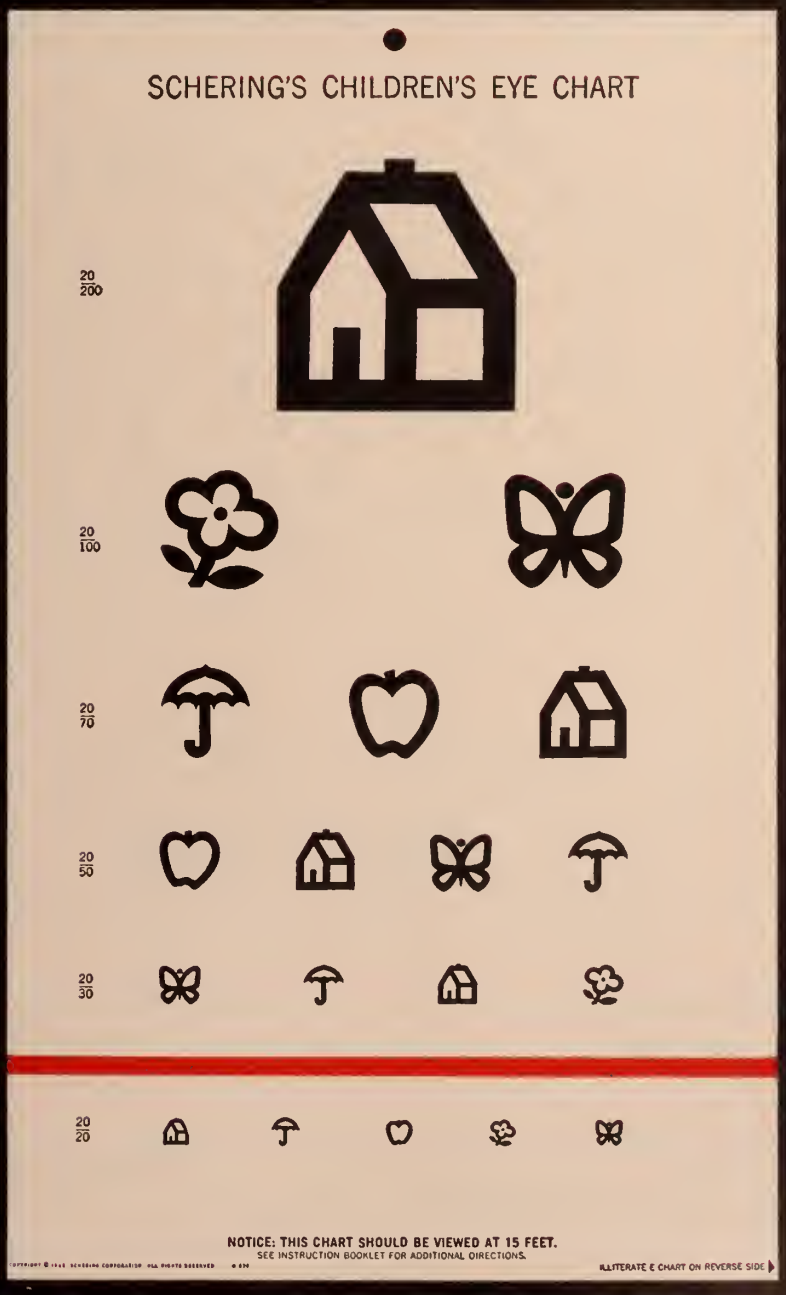
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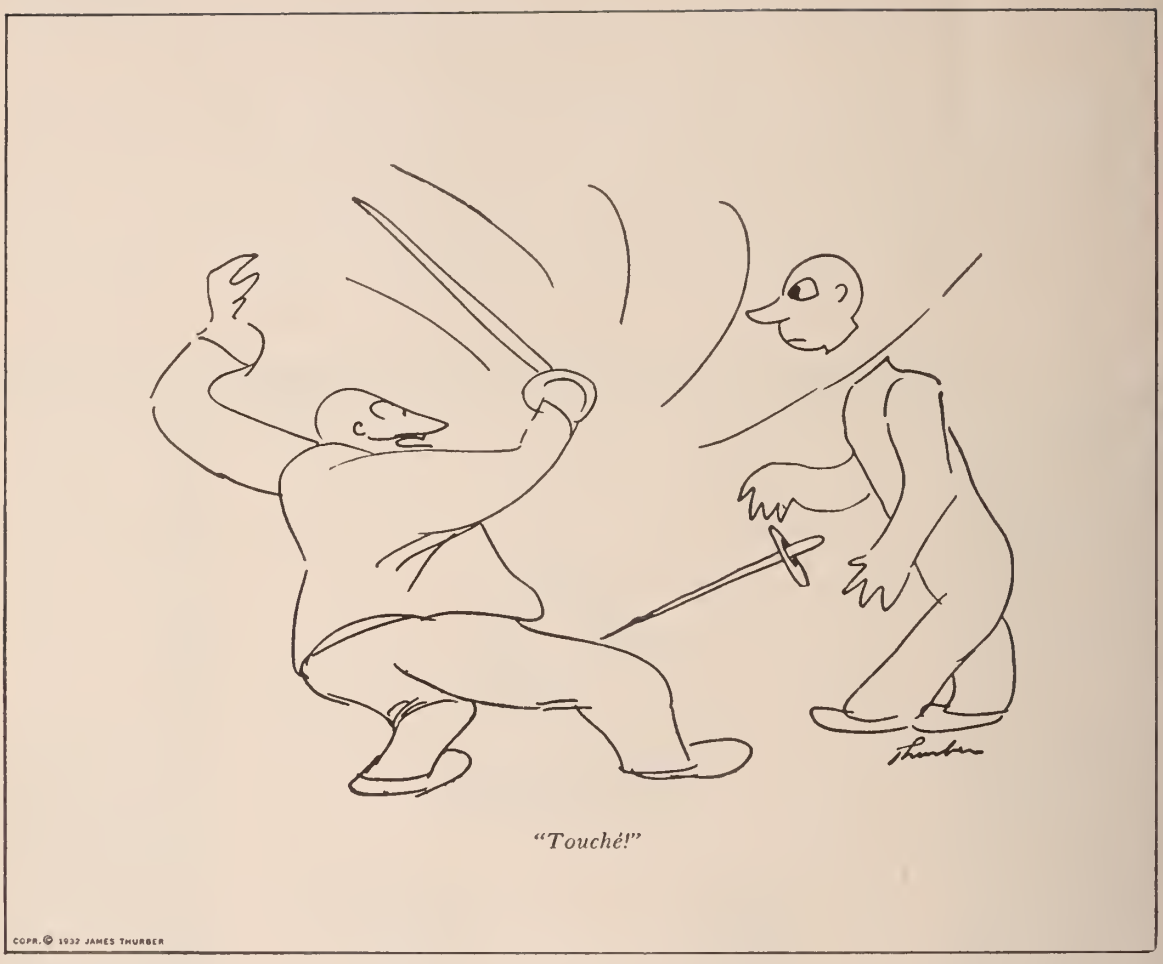
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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Dr. Aldrich C. Crowe 1898 - 1961

Small towns and less populous counties have made rich contributions to our profession and our organizational life. An example is the career of Dr. Aldrich C. Crowe, who is identified with Cape May—one of our smaller counties—and who, in every sense, was one of our "bigger" men. Born in Alabama, Dr. Crowe went to the University of Chicago for his baccalaureate work and to the Jefferson Medical College of Philadelphia for medical studies. After being graduated from Jefferson in 1921, he won one of the exclusive and much coveted "Blockley" internships, so that it was apparent that even at the age of 23 he was marked for advance. During that internship, he decided that, while he would remain a general clinician always, he was particularly interested in our nation's greatest asset: its children. In 1922-23, when residencies were still rare, he returned to Alabama to serve as a pediatric resident at Birmingham's Baptist Hospital. He then looked over the country and decided, much to our advantage, to settle in New Jersey.

In 1925 he came to Cape May County. Within two years—at the age of 29—he was elected Councilor from the Fifth District—an extraordinary tribute to a man so young, who was still in a sense a "newcomer." His rise thereafter was meteoric. Within six years he was on the State Board of Trustees. By 1939 he had become president of the Cape May County Medical Society. The next year he was secretary of the Board of Trustees, and in 1946 he became chairman of that Board. A year later he became second vice-president, and in 1950,

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 681

VOL. 58, No. 5 MAY, 1961 Subscriptions, $3.00 per year
Single Copies, 30 Cents

he was elected President of The Medical Society of New Jersey.

Paralleling this career was a ferment of activity in other aspects of organizational work, and in clinical pediatrics too. He was picked as national vice-chairman of the A.M.A. Section on Diseases of Children. He became chief of pediatrics at the Atlantic City Hospital and consultant at Burdette Tomlin. On the organizational side of his career, Dr. Crowe served us in many capacities—adviser, consultant, chairman of many committees, and AMA Delegate. In his life and work he exemplified the rule that somehow a busy man always finds time for important additional responsibilities. He was, in every sense of that word, a true leader.

Dr. Lewis C. Fritts 1903 - 1961

Only fourteen physicians now have the rare distinction of Fellows of The Medical Society of New Jersey. This small company represents a carefully selected and truly distinguished group. By the time a man reaches that status, he has shown that he has something that marks him as an unusual practitioner.

Dr. Lewis C. Fritts was one who attained that rare distinction at the age of 53. A New Jersey native, he first entered the field of the natural sciences, but in 1926 transferred his interest and affection to medicine and matriculated at the Jefferson Medical College. On earning his M.D. in 1930 he again demonstrated his talent for being of a small company, when he was chosen for one of the highly-prized "Blockley" internships. After completing this service, he tried out for and was awarded a fellowship in surgery at the Cleveland Clinic. Completing this in 1935, he returned to his native state and entered private practice in Somerville.

In Somerset County his advancement was rapid. It was said in Somerville, that if there was any activity for civic betterment, Lew Fritts would be in the thick of it. He was. He served, for example, as president of the Somerville Rotary Club—again demonstrating the adage that no matter how busy a clinician is, he can find time—he should find time—to contribute to his community; to contribute not only money, but also time, talent, heart and energy. Six years after he came to Somerville, he became president-elect of the Somerset County Medical Society, a rare tribute for one so recently come to a community. But Lewis Fritts was accustomed to rare tributes.

In organized medicine at the State level, Dr. Fritts was a driving force. He was on many committees, and chaired most of them at one time or another. He was a trustee, and in 1953 he became second vice-president of The Medical Society of New Jersey. Thereafter he ascended the presidential ladder and was the chosen leader of our society in the 1956-57 year.

During the past few years he was not always well physically. But nothing could quench the ardor of his spirit, or his zeal for doing what had to be done. No psychologist, no sociologist has ever figured out the formula for recognizing in advance the man of stature; nor for putting one's finger on the exact qualities of heart and mind that spell leadership. But whatever the secret of leadership may be, Lewis C. Fritts knew it. His death at the age of 58 is untimely and sad. We in the offices of The Medical Society will miss him though we are glad that he was with us as long as he was. His heritage to us will long remain.

F. Clyde Bowers, M.D.

Mendham

The General Practitioner*

Present and Future

The increasing glamor of the specialties has, for several decades, decreased the attraction of general practice for new doctors. But, as our Past-President here indicates, there is new hope for an inspiring renaissance for the general practitioner.

I am pleased and flattered to have been invited to address you on the topic, "The present and future of the general practitioner." Many in the past have considered—as some still do—that the terms "general practitioner," "family doctor" and "country doctor" all describe the same individual. Although some physicians could still qualify for all three titles, there are many general practitioners who either do not so qualify or are not so considered.

The country doctor is no longer distinguishable in most areas because of the urbanization of our population, the ease of transportation, and the speed of communication. Our image of the country doctor as the rugged individualist, the selfless and dedicated professional, the kindly but lonely old man is just a sentimental picture now in the gallery of Medicine's Hall of Fame.

The general practitioner can more justly lay claim to the title of "family doctor." This was truer 25 years ago than it is today. Now he must share this distinction with the internist who, although a specialist, is often considered as the family physician. In a truer sense, the general practitioner has always been looked upon as the doctor who treats everybody for everything. However, in the past quarter of a century this concept has gradually changed, and it is continuing in its evolutionary development.

It became apparent a few decades ago that, as the science of medicine broadened its base, there was increasing need for specialization. The first specialists were general practitioners who decided to devote their entire efforts to one branch of medicine. These early specialists, although not as well trained in the basic sciences as their present-day counterparts, had a wealth of practical experience in both the science and art of medicine as a whole. Would that our specialists of today had a similar background of practical training as well to complement and round out their book knowledge!

A good general practitioner is the greatest specialist of all. He must not only be expert in all the diseases that harry his fellowmen; but he must also be learned in the foibles of people. Only with this kind of knowledge can he properly handle the many who seek his advice and care.

The "generalist" of a generation ago and his present day analogue differ in some very important respects. It may be assumed that today's general practitioner will likewise display some differences when compared with his successor a generation hence.

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* Delivered by invitation Dec. 1, 1960 before the Morris County Chapter, American Academy of General Practice meeting in Morris Plains, N. J.

This must be expected and accepted as evolutionary change—or progress, if you will.

Many factors through the years caused this change in general practice and, in consequence, in the general practitioner. The primary cause was the amount of amassed scientific knowledge which gave birth to specialization. Specialization was necessary to improve the efficiency of health care; but unfortunately the emergence of specialization forced the general practitioner to a lower rung on the professional ladder. For centuries all physicians had been considered more or less in the same category, professionally and socially. I need not elaborate upon how this move into specialization created a caste system in some areas and produced a false stigma around the "generalist." This, in turn, led general practitioners to band together to form the Academy of General Practice. This is the largest single organized group of medical practitioners in the field of medicine today and is a credit to the profession. This organization has wrought profound changes in the field of general practice, favorably affecting both the welfare of the patient and the practitioner.

Something more subtle though, has been responsible for the greatest changes in general practice today and in the practice of medicine in its entirety. The reference is to the great social revolution in the world starting in the 1930's and still continuing. We have seen how the general practitioner has improved his professional standing by his own efforts, but the alterations caused by the vicissitudes of society, either good or bad, are beyond his control. One social instrument that has had a far-reaching effect is health insurance in all its forms. Despite all its faults, we must admit that insurance alone has been greatly responsible for the improved financial status of the general practitioner. Fuller employment at better wages, a higher standard of living, and a more adequate education and compensation for the average worker during this interval of social and economic change have also served to increase the income of the "generalist."

Professionally and financially then, it would appear that the general practitioner of today enjoys a more satisfactory status than his predecessor of a generation ago. Now let us have a look at his social position.

Some twenty-five or thirty years ago, all physicians, regardless of professional status, were —as had been the custom down through the years—invested with a cloak of dignity that inspired the reverence and commanded the respect of the entire community. Physicians as a whole, and "generalists" in particular can no longer lay claim to this advantage to the extent to which it was formerly enjoyed. The reason is multi-faceted but primarily is due to the fractionization and socialization of medicine, both the result of the change in our social order. The lofty social pedestal which the physician alone once held must now be shared with the chemist, the industrial engineer, the social worker, the hospital administrator, and many other skilled technicians and experts who have become members of the health team. This revolutionary process could conceivably continue in its invasive and anarchic bent until it caused the complete disorganization and disintegration of the practice of medicine. On the other hand, it can be stopped and the process of inevitable change be made to proceed in an orderly fashion so as to preserve the health and protect the welfare of the people of this nation. In this constructive activity, the general practitioner should play the leading role.

Very sketchily this is the picture of the present day general practitioner as he looks to me professionally, economically, and socially. What, then, of the future?

First, let me say that I profess no special powers or ability as a prophet. But I do have great faith in the American people and the American way of life, so I feel relatively safe in making a prediction about the future of the general practitioner of medicine. I am confident that the future of the general practitioner, as an individual—though possibly as a different individual than presently recognized—is assured. He will be better professionally, will be

rewarded at least as well financially, but will be in a different position socially. General practice will become narrower in concept but more delimited in character. I foresee the "generalist" limiting his field to internal medicine, pediatrics, geriatrics, and minor office surgery. He will be truly the family doctor in whom the public will have greater confidence. Because of his better professional training and the limitation of his practice, he will be better equipped to diagnose and treat diseases within the sphere of his capabilities, at the same time recognizing and referring to appropriate colleagues those cases requiring other skills. He will become more active academically, teaching the necessary skills required of a family doctor. Participation in organized medicine will be more extensively indulged by the "generalist" because of his intimate family contact. These activities, among others, will enhance his social position. The practice of medicine will continue to be fragmented. Many of today's auxiliary medical workers will be tomorrow's collaborators seeking to share in the professional limelight. But the general practitioner will be on top of the pyramid, for the reasons that I now offer.

Among the learned professions medicine has set an enviable record, and American medicine in particular has reached heights unrivalled. Most of us believe that the unique status of American medicine should be credited to free enterprise under our system of government. Traditionally, the American public expects to have family doctors, and our entire system (which has thus far been so successful) depends primarily upon well trained general practitioners. They form our first line of defense against illness and, consequently, are the first to be approached by an ill person. Surely, such a system which has been proved by time will not be readily abandoned by a well-informed, right-thinking American public in favor of any other system, least of all one that is government-financed. It is, therefore, the duty of every physician—and especially of every general practitioner—to make sure that the public is well and accurately informed and is not deceived by social planners and bureaucrats.

It is true that with continuous research and invention the practice of medicine has become more scientific and therefore more exacting. It is equally true that there has been an increase in growth of the clinic and group practice. Again it must be admitted that specialists other than physicians have become members of the health team. Yet, in the last analysis, the doctor of medicine is still and should always be the key figure, responsible for promotion of health and the relief and cure of disease. In addition, no amount of scientific medicine can ever replace the traditional physician-patient relationship unless human emotions change.

In light of what has been said I must conclude that the future of the general practitioner looks bright provided he does not let his advantage go by default. He must be in the forefront of those proclaiming the virtues of our present system of medical practice, and be energetic in exposing the unsound thinking of those who would substitute state medicine. Let us not permit the welfare of our people to be jeopardized by a welfare state.

1 Mountain Avenue

Honor to Ex-State Board Members

The Federation of State Boards of Medical Examiners has announced the election to Life Honorary Membership of the following New Jersey physicians who, during the years indicated, served on our State Board of Medical Examiners:

Robert N. Bowen	1954-58
John H. Rowland	1939-60
Royal A. Schaaf	1942-60
Elmer P. Weigel	1942-61

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East Orange

Treatment of Combined Mitral Insufficiency and Stenosis by Open Heart Method*

Report of Five Consecutive Successful Cases

Previous efforts to correct mitral insufficieney by surgery have often failed because the surgeon had to work in the blind. The "open heart" method here described avoids this hazard.

During the past few years a variety of surgical procedures have been used in an attempt to correct mitral insufficiency. These methods have largely been abandoned, however, because, being "blind" methods of approach to the mitral valve, they did not allow adequate repair in spite of all the dexterity and experience of the surgeon. A logical approach to the mitral valvular insufficiency has been brought about by the advent of extracorporeal circulation. From the surgical point of view, the open heart method in the correction of the insufficiency should be more feasible in most instances. To date we have operated *under direct vision* on five patients with advanced mixed mitral stenosis and insufficiency. We have had no operative mortality and the results so far seem to be satisfactory and to justify continuation of such an approach to the mitral valve.

*From the combined Cardiac Departments of the Hospital Center at Orange, N. J., and Mountainside Hospital, Montclair. This project was supported in part by the New Jersey State Department of Health and the Victoria Foundation.

TECHNIC

Exposure of the mitral valve is achieved through a right anterior thoracotomy incision at the level of the 5th interspace. The sternum is transected at this level. The left pleural cavity is not entered. Extracorporeal circulation is instituted after cannulation of the vena cavae through the right auricular appendage and of the left common femoral artery. Once the patient is on complete cardiopulmonary bypass, the left atrium is widely incised just posterior to the interatrial sulcus. A specially designed suction tip is introduced into the heart chamber and the left auricle emptied of its blood content. Just enough blood is left in the heart to cover the mitral orifice. Cardiac arrest is not used since ventricular action is required so that the surgeon can assess the function of the valve and ascertain the area from which regurgitation originates. Thus, if there is any absolute or relative valvular deficiency or perhaps a systolic eversion of a

portion of the leaflet secondary to ruptured chordae tendinae, the valve can be studied under direct vision. Having made an estimate of the situation, the surgeon then passes the intracardiac suction tip into the left ventricle and enough blood is withdrawn to allow clear visualization of the mitral valve. The stenosis, if present, is relieved by opening the anterior and posterior commissures to the ventricular wall. The insufficiency is then corrected by narrowing the mitral ring with several mattress sutures of silk carefully placed so that, at the end, the valve ring ratio would come back to normal and the insufficiency is nearly entirely corrected. The suction tip is removed from the left ventricle from time to time allowing the ventricle to fill with blood. Thus, the efficiency in closure of the mitral valve is re-evaluated. If this closure is satisfactory, the left atrium and ventricle are then allowed to refill with blood while the atriotomy is being repaired. At this time the extracorporeal circulation is terminated.

CASE ONE

This 38-year old housewife was admitted with palpitation, increased shortness of breath and fatigue. She has had rheumatic heart disease since 14. Three months prior to this admission she was at Overlook Hospital in Summit with symptoms of heart failure and an episode of transient facial paralysis. Following the usual medical therapy (digitalis and anticoagulants) she improved and was discharged to a convalescent home with diagnosis of advanced mitral stenosis and insufficiency and pulmonary hypertension. Her dyspnea improved somewhat but weakness and palpitation on minor exercise persisted. In January 1960, she was admitted to Orange Memorial Hospital. Pertinent physical findings at this time were: blood pressure 118/80; lungs clear to auscultation; the heart fibrillating with the point of maximal impulse at the 5th intercostal space in the midclavicular line; P2 exceeding A2 but splitting of the second pulmonic sound could not be heard. There was a mid-diastolic blowing murmur audible along the left sternal border and a short rough presystolic murmur, well localized, at the apex. At the apex only there was a Grade II blowing systolic murmur and an early diastolic murmur. An opening snap could be heard along the left sternal border. X-ray showed cardiomegaly with enlarged left atrium and calcified mitral valve as well as a great deal of pulmonary congestion. Cardiac catheterization demonstrated moderate pulmonary and right ventricular hypertension. After exercise the pulmonary arteries rose sharply to levels approaching that of the systemic circulation. The pressure in the pulmonary arterial capillaries which reflects the left atrial pressure was significantly elevated with a high V-wave during ventricular systole. The configuration of the pressure pulse was indicative of severe mitral stenosis and mitral insufficiency. The systemic blood flow was markedly reduced and the pulmonary vascular resistance markedly elevated.

The patient was operated on by the technic described above. The valve was found to be calcified over the medial aspect, preventing adequate closure of the mitral leaflets. The opening of the mitral valve was 15 millimeters in diameter and cone-shaped. The chordae tendinae were shortened and adherent to each other.

The commissures were opened with scissors out to the ventricle. The chordae tendinae were separated under direct vision. It was then found that the closure of the mitral valve was quite satisfactory except over the medial commissure where a full blown regurgitant jet of blood persisted. Correction was done by closure of the mitral ring with three mattress sutures. This was enough to stop the regurgitant jet. The air in the left ventricle was replaced by blood and the incision in the auricle was closed. The patient was taken off the heart-lung machine. She had been on cardiopulmonary bypass for 35 minutes. Since the patient had a known pulmonary hypertension, a tracheostomy was done and for the three postoperative days she was kept on a respirator. The postoperative course was uneventful and she was ambulatory on the seventh postoperative day. Electrocardiograph three weeks later showed definite decrease in the right ventricular strain pattern. X-ray at the time of discharge showed the pulmonary vasculature to have returned to about normal. The patient at this time (fourth month postoperative) is carrying out a full day's work with no apparent respiratory difficulty.

CASE TWO

This 46-year old woman was admitted to Orange Memorial Hospital with symptoms of weakness and dyspnea on exertion. She had had rheumatic fever as a child and had been known to have a heart murmur from the age of 4. She suffered yearly attacks of rheumatic fever between the ages of 4 and 9. Nine months prior to this admission her disability became much more pronounced in spite of active medical treatment. On admission she had a fibrillating heart and a blood pressure of 108/62. The liver was seven centimeters below the costal margin. Cardiac auscultation revealed the classical signs of mitral stenosis and insufficiency. X-ray showed cardiomegaly with marked enlargement of the left atrium and right ventricle, a large amount of calcium deposit over the mitral valve, increased pulmonary vascular markings and signs of pulmonary hypertension. The data obtained from cardiac catheterization showed extreme elevation of the pulmonary artery pressure to levels exceeding that of the aorta.

The left atrial pressure as measured by direct transthoracic catheterization of this chamber was significantly elevated. The left atrial pressure pulse configuration indicated both severe mitral stenosis and moderate mitral insufficiency. The pulmonary vascular resistance was extremely high, approaching that of the systemic peripheral vascular resistance.

Open repair of the mitral valve was carried out. The valvular abnormality encountered consisted of a narrowing of the orifice to 1.5 centimeters in diameter and heavily encrusted by a large deposit of calcium, giving it a "buttonhole" shape. A regurgitant jet of blood through this opening was present. The commissures could be opened to the ventricular wall under direct vision with ease and accuracy. With three strategically placed mattress sutures, the enlarged mitral ring could be constricted so that the insufficiency was nearly completely corrected. Postoperative recovery was satisfactory though slow. Because of the preliminary hypertension she was kept in the hospital for five weeks postoperatively. X-rays at the time of discharge showed dramatic improvement in the cardiovascular silhouette, compared to the pre-operative film. The hepatomegaly had disappeared. The patient was ambulatory and the shortness of breath had become much less noticeable.

CASE THREE

This 32-year old woman had been followed at the cardiac clinic of Orange Memorial Hospital for many years with the diagnosis of rheumatic valvulitis. While living in New Orleans, she had developed a left-sided empyema in 1950 requiring decortication. In 1953, at term with a pregnancy, she went into congestive heart failure and the diagnosis of mitral stenosis was then made. The heart failure was alleviated and delivery was uneventful.

In 1955, mitral commissurotomy was done by the closed method. She did well for two years. She required no cardiac medication or salt restriction. In 1957, however, she developed increasing evidence of pulmonary congestion and medical therapy had to be reinstituted. Six months prior to the present operation, the patient went into chronic congestive heart failure with episodes of paroxysmal auricular fibrillation and persistent dyspnea or orthopnea. A diagnosis of restenosis of the mitral valve together with insufficiency was made. X-rays showed substantial calcification of the valve. Right heart catheterization was done in January 1960. This revealed moderate pulmonary artery and right ventricular hypertension and evidence of right ventricular failure. After two months of delay (because of the patient's previous failure) left heart catheterization was performed March 3, 1960. This demonstrated a 20 millimeter gradient across the mitral valve during atrial systole, indicating a high degree of mitral stenosis. The V-wave which coincides in time with ventricular systole was somewhat higher than the C-wave produced by closure of the atrial ventricular valve and suggested some mitral insufficiency.

The patient was operated on and the mitral valve exposed as described above. A mixed type of stenosis and insufficiency was found. Repair of the valve was carried out as before and the insufficiency corrected by constricting the mitral ring with three interrupted mattress sutures over the posterior commissure. The postoperative course was uneventful except for a transient psychotic episode which subsided spontaneously. Shortness of breath gradually improved. She was then transferred to an ambulatory convalescent home for a month's recuperation, quite in contrast to the preoperative condition of being completely bed-ridden.

CASE FOUR

A 35-year old housewife was admitted to the Orange Memorial Hospital with the diagnosis of mitral stenosis and insufficiency. Her chief complaint was shortness of breath on moderate exercise and a sense of weakness. She had been told she had a heart murmur five years previously during the fourth month of pregnancy at which time she went into heart failure. Ever since she had been going in and out of failure in spite of active medical therapy. At the time of admission she had two-pillow orthopnea and a chronic cough, aggravated by the recumbent position, relieved when sitting up. There was bilateral ankle edema and "half-flight" dyspnea. She had a Grade II presystolic murmur best heard at the apex and a Grade II blowing systolic murmur most prominent along the left sternal border. The diagnosis was rheumatic heart disease with mitral stenosis and insufficiency, Grade IV. At right and left heart catheterization, the pulmonary artery pressure was only slightly elevated and the wedge pressure at rest was only slightly above the normal value; however, during exercise the wedge pressure rose to a mean value of 40 millimeters of mercury. This level is in the range which produces pulmonary edema. After exercise the wedge pressure returned to almost normal value. The left atrial pressures were found to be higher than the wedge pressures measured in the pulmonary arterial bed. There was an atrial systolic gradient of 15 millimeters across the mitral valve. The pressure pulse configuration did not indicate any significant mitral insufficiency. There was no abnormal gradient across the aortic valve. The cardiac output was moderately reduced to 3.3 liters per minute and the pulmonary vascular resistance was within normal limits. Open repair of the mitral valve was carried out. The valvular abnormality encountered consisted of a tear-shaped narrowing of the orifice to 6 millimeters in diameter. A regurgitant systolic jet was noticed through the center of the stenotic valve. The mitral valve was opened to the wall of the ventricle by use of a scissors and, in spite of this maneuver and the mobilization and separation of the shortened chordae tendinae, the insufficiency was still present. It was obvious that there was not enough mitral valvular tissue to close the dilated ring. Mattress sutures were placed over the posterior commissure and the regurgitant jet was thus decreased by at least 90 percent. The post-

operative course was satisfactory and the patient was discharged at the end of the second postoperative week. Three weeks later the presystolic murmur had disappeared and there was no longer a snapping quality to the pulmonic second sound.

CASE FIVE

This 38-year old housewife was admitted with symptoms of shortness of breath and fatigue. Diagnosis of mitral stenosis and insufficiency had been made at the cardiac clinic of East Orange General Hospital where she had been hospitalized twice before for symptoms of heart failure and one episode of cerebral embolization. Pertinent physical examination showed a normal physiologic splitting of P-2 and an ejection-systolic murmur at the base. At the apex there was a prominent first sound with a regurgitant systolic murmur, opening snap and also a diastolic filling murmur. Along the left sternal border a regurgitant diastolic murmur was heard. Clinical diagnosis was mitral stenosis and insufficiency, possible mild aortic disease of no pathologic significance and atrial fibrillation. Patient was presented to the cardiac conference and a right heart catheterization was advised. Right heart catheterization demonstrated slight elevation of the wedge pressure. The configuration of the left atrial pressure pulse showed a marked elevation of the V-wave of ventricular systole. The pulmonary artery pressure was normal at rest and rose moderately during exercise. Systemic blood flow was estimated at two liters per minute. Left heart catheterization was not done since the wedge pressure indicated moderate mitral stenosis and a very significant mitral insufficiency. This conclusion was supported by the fact that after exercise (although the end diastolic pressure in the wedge position rose moderately) the V-wave rose considerably out of proportion to the former, thus suggesting the predominance of mitral insufficiency. The patient was operated on by the previously described technic. The mitral valve was found free of appreciable amount of calcification. The aortic leaflet of this valve was held down by shortened chordae tendinae and during systole it could not meet the free edge of the mural leaflet, thus causing a wide regurgitation of blood from the left ventricle into the left auricle. In the meantime, there was a moderate degree of stenosis present. This was relieved easily and accurately by sharp incision of the scarred commissures. The chordae tendinae were visualized and split longitudinally, giving them enough length to allow for better approximation of the mitral leaflets. The mitral ring was constricted, as mentioned previously, enough to decrease the amount of regurgitation to practically nil. The left ventricle was allowed to fill with blood and under direct vision the competency of the mitral valve was rechecked and found satisfactory. The left auricle was filled with blood and the auriculotomy was closed in the usual manner. The postoperative course was entirely uneventful. She was ambulatory on the third postoperative day and, interestingly enough, she noticed improvement in her breathing only five days after surgery.

In 1929 Cutler and Beck[1] attempted to relieve mitral stenosis by producing mitral insufficiency under the assumption that the latter was better tolerated than the former. Twenty years later Horace Smithy[2] revived this concept and probably was the greatest stimulus in re-awakening interest in the surgical treatment of rheumatic valvular disease. Subsequent surgical experiences, however, showed that significant mitral insufficiency may be of more serious import than mitral stenosis. A review of our own series[3] of over 150 cases of mitral commissurotomy reveals that the majority of late postoperative complications occurred in patients with persisting insufficiency. A variety of surgical procedures have been tried in the past few years in an attempt to correct or palliate the mitral valve incompetence. Most of these methods have been abandoned. Their failure was due to the fact that the corrective measure was taken "blindly" and there was no way for accurate visualization of the valve. Pure mitral insufficiency is rare and is usually the result of an acute trauma causing a hole or a defect in the valve leaflet or rupture of papillary muscle or tendon. Surgical correction of these abnormalities is feasible and effective. Infinitely more common is the mixed type of valvulitis producing rigidity, contracture or calcification of the leaflets. Once the insufficiency is established it becomes a progressive process since the dilatation of the annulus leads to a further increase in the degree of insufficiency, thus producing a vicious cycle. In the absence of an ideal prosthesis to replace the damaged mitral valve, one can obtain a sufficiency of the valve by reducing the size of the annulus and thus re-establishing the normal annulus valve ratio. This can be helped further by mobilization of the valve tissue itself and the chordae ten-

1. Cutler, E. C. and Beck, C. S.: Archives of Surgery, 18:403 (1929).

2. Smithy, H. G. and Parker, E. F.: Surgery, Gynecology and Obstetrics, 84:625 (1947).

3. Sabety, A. M. and Ewing, H. D.: JOURNAL of The Medical Society of New Jersey, 55:418 (August 1958).

dinae. Occasionally, accurate removal of the concomitant stenosis restores to a remarkable degree the coaptation of the valvular leaflets.

SUMMARY

1. Open-heart surgery using extracorporeal circulation has replaced the previously employed "blind" method used to correct mitral valvular insufficiency.

2. By this method, five consecutive cases of mixed mitral stenosis and insufficiency have been operated on with no operative mortality and very satisfactory results, suggesting that this technic should be continued as the method of choice for repair of this type of rheumatic heart disease.

144 South Harrison Street

Low Salaries Do Not Protect Against Heart Attacks

Heart attacks occur more frequently among lower-salaried male employees than among those in higher brackets, a study of the personnel of a large industrial firm indicated. A survey of first heart attacks among duPont personnel was reported by Sidney Pell, Ph.D., and C. A. D'Alonzo, M.D. in the February 11, (1960) *Journal of the American Medical Association.*

The company population averaged 90,000 persons ranging in age from 17 through 64. There were 13,788 women in the group.

Male employees were divided into five brackets on an economic basis and level of job responsibility. The study showed that the incidence of heart attacks was lowest among the highest salary groups, being 2 per 1,000 persons per year. In the second highest salary group, the rate was 2.4 per 1,000 and the rate rose to 3.8 and 4 per 1,000 in the two lower-salaried groups.

The fifth, or "wage roll," group consisted of skilled, semi-skilled, and unskilled production workers who, on the whole, were more physically active at work than those in the other four classifications. The heart attack rate in this group was 2.9 per 1,000 persons per year.

"Our data are inconsistent with the idea that the increased responsibility of men at the upper levels of management increases susceptibility to coronary disease. Although stress may be a factor in the development of the disease, the level of job responsibility is not necessarily an indicator of the degree of stress to which an individual is subjected.

"Persons occupying higher managerial positions derive satisfaction from the demands of their jobs, while those with a minimum of responsibility may suffer from feelings of resentment and frustration due to lack of personal fulfillment and their relatively low position on the scale. Also, the lower incidence of coronary disease in the wage roll group may be due to more physical activity, rather than to less emotional stress, both on and off the job.

"In choosing persons to assume greater responsibilities, supervisors and managers select better adjusted individuals, who by virtue of their personality are better able to cope with life's stresses in general."

Of the 653 employees who had their first heart attack during the study, only 13 were women. None was under 45 years of age. In the 45 to 54 age group, the incidence rate in men was 10 times that of women. But the rates among women tended to approach those of men after the age of 55.

This probably reflects the loss of female hormonal protection against hardening of the coronary arteries after the menopause.

Chances of survival were reduced if the attack occurred between midnight and 6 a.m. During the waking state, the defense mechanisms of the body respond more quickly and adequately. "It is also possible that the lower case fatality rates during the morning and afternoon may be due to greater accessibility of medical attention at those times."

The incidence of attacks reached a peak between 9 a.m. and 12 noon and a smaller peak between 6 and 9 p.m. But only 5.4 per cent of the attacks occurred while the person was engaged in strenuous activity.

The fatality rate (3.4 per cent of all those stricken) was increased in patients 50 years of age or older and in those with high blood pressure. Chances of surviving were not affected by overweight or the degree of physical activity at the time of the attack. Most of those who suffered a heart attack showed no electrocardiographic abnormalities one to two years before the attack.

E. William Jewell, M.D.

Ridgewood

Therapy of Dermatomycoses with Griseofulvin*

The promise of griseofulvin has, apparently, been confirmed after three years of trial. Most patients with superficial fungous disease did respond to it. It did not help psoriasis.

Infections produced in human hair, nails, and the surface of the epidermis by fungi of the genus Trichophyton, Microsporum, or Epidermophyton are prevalent. They are often intensely pruritic, occasionally disabling, and notably discouraging to treat. For these reasons, preliminary reports [1-3] that an oral agent, griseofulvin, was effective against most types of superficial fungous diseases were greeted and confirmed with enthusiasm.[4-10] This report is a resume of results of therapy utilizing griseofulvin in a private office practice. It offers further evidence of the usefulness and limitations of this new antimycotic agent.

METHODS

Griseofulvin† was used to treat 45 patients with tinea pedis, 17 with tinea manuum, 27 with tinea unguium, four with tinea cruris, three with tinea corporis, and five with tinea capitis. The pathogens were identified in culture (see table) for the 89 patients in the first three diagnostic categories. The patients ranged in age between two and 65 years. The dosage was 0.5 to 1 Gram daily. Duration of therapy varied between one week and seven months. Most patients also received standard topical medication such as unsaturated fatty acids and keratolytic and drying agents. Ten patients with psoriasis received griseofulvin experimentally.

*Portions of this paper were presented before the Dermatology Section of The Medical Society of New Jersey at its Annual Meeting on May 17, 1960.

†Griseofulvin (Fulvicin®) was provided by G. Kenneth Hawkins, M.D., of the Medical Research Division, Schering Corporation, Bloomfield, New Jersey.

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2. Riehl, G.: Griseofulvin: An Orally Effective Antimycotic. Presented at a Meeting of the Austrian Dermatologic Society, Vienna, 1958.

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10. Yontef, R.: Journal of The Medical Society of New Jersey, 56:738 (1959).

TREATMENT WITH GRISEOFULVIN

	T. mentagrophytes 25 Patients		T. rubrum 51 Patients		E. floccosum 13 Patients		Summary by Site, 89 Patients	
Tinea pedis 45 patients	Cured	2 (14%)	Cured	9 (43%)	Cured	3 (30%)	Cured	14 (31%
	Improved	9 (64%)	Improved	9 (43%)	Improved	3 (30%)	Improved	21 (47%
	Failed	3 (22%)	Failed	3 (14%)	Failed	4 (40%)	Failed	10 (22%
Tinea manuum 17 patients	Cured	2 (33%)	Cured	7 (70%)	Cured	1 (100%)	Cured	10 (59%
	Improved	4 (67%)	Improved	1 (10%)	Improved	None	Improved	5 (29%
	Failed	None	Failed	2 (20%)	Failed	None	Failed	2 (12%
Tinea unguium 27 patients	Cured	None	Cured	2 (10%)	Cured	1 (50%)	Cured	3 (11%
	Improved	4 (80%)	Improved	14 (70%)	Improved	1 (50%)	Improved	19 (70%
	Failed	1 (20%)	Failed	4 (20%)	Failed	None	Failed	5 (19%
							General Summary, 89 Patients	
Summary by pathogen, 89 patients	Cured	4 (16%)	Cured	18 (35%)	Cured	5 (38%)	Cured	27 (30%
	Improved	17 (68%)	Improved	24 (47%)	Improved	4 (31%)	Improved	45 (51%
	Failed	4 (16%)	Failed	9 (18%)	Failed	4 (31%)	Failed	17 (19%

RESULTS

RESULTS in patients with tinea pedis, tinea manuum, and tinea unguium are summarized in the table. Of these 89 patients, 72 (81 per cent) were cured or improved. The best cure rate among these three groups occurred in tinea manuum; and the lowest in tinea unguium. By adding the number of cures to the number improved, it is seen that some degree of satisfactory response was obtained in 80 per cent of each of the three groups. This suggests that griseofulvin has limitations by virtue of local conditions most favorable to infection and reinfection, and would otherwise be equally effective in all areas of the integument.

In *tinea pedis*, absence of clinical evidence of infection and negative laboratory findings indicated "cure." The condition was considered "improved" if there was significant relief of pruritus, vesiculation, scaling, fissuring, and inflammation. Results were somewhat better in infections caused by T. rubrum than in those due to T. mentagrophytes or E. floccosum. Of the ten failures recorded among these 45 patients, six were relapses either during therapy or six to nine weeks after apparent cure and discontinuance of medication. These ten patients had been treated for at least six weeks. Three had been treated for 18 weeks.

All but two of the 17 patients with *tinea manuum* were cured or improved by griseofulvin. All but one of the patients in this category also had involvement of the feet or nails or both; the response in these latter sites paralleled the response in the hands, possibly indicating previous continuous autoinfection.

The results in *tinea unguium* were disappointing. After two to six months of treatment only three of 27 patients were cured. Two of these three had infections in only a few of the nails; these were avulsed during treatment with griseofulvin and normal nail grew in postoperatively. In 19, there was some improvement evidenced by clearing in some nails while others were not improved, or, surprisingly, appeared to grow worse. Toenails responded less favorably than did the fingernails. The nails of the halluces and pollices responded less favorably than other nails. Variations in thickness, rate of growth, and environmental factors of heat, moisture, and darkness probably account for these differences.

The four patients with *tinea cruris* were cured in two to nine weeks of treatment with griseofulvin and the three patients with *tinea corporis* were cured in less than two weeks. *Tinea capitis* in five patients was clinically cleared and the hair was negative to Wood's light examination after two to seven weeks.

None of the ten patients with *psoriasis* was improved by griseofulvin. A few showed aggravation of existing lesions.

SIDE EFFECTS

There were 24 side effects in 17 (15 per cent) of 111 patients treated. Gastrointestinal symptoms (anorexia, nausea, cramping, flatus, diarrhea) and headache were each reported nine times. Only two of the latter patients prematurely discontinued griseofulvin because of the headache. In the others, this symptom disappeared when dosage was reduced from 1 to 0.5 Gram. Malaise and lassitude generalize the complaints of three patients of "stiff bones," dullness, or fatigue. Side effects, although rather frequent, were insignificant, usually disappeared spontaneously, and seldom made it necessary to discontinue the medication.

Three patients with known allergy to penicillin tolerated griseofulvin without ill effect. Two or more differential white blood cell counts were performed in 23 patients treated for as long as six months. There was one instance of a decrease of the leucocytes to below 6,000 per cubic millimeter but the level returned to normal despite continued administration of griseofulvin.

Review of the Literature. Most clinical investigators do periodic differential blood counts and urinalyses on patients who receive griseofulvin. Although physiologic variables are rarely affected by this drug, a few reports of slight and transient leucocyte depression or albuminuria stimulated more elaborate laboratory studies of the possible toxic effects of griseofulvin.[11-14] Tests of liver and kidney function were done by Livingood and colleagues [11] among patients who received griseofulvin for several months. McCuistion and colleagues [13] also made such studies. All had normal results. Testicular biopsies [12] indicate that griseofulvin does not impair spermatogenesis.[13] McCuistion and colleagues [13] observed a slight transient right shift in the peripheral blood counts of a few patients and Williams and Moyer [14] reported two instances of transient leucocyte depression. Differential counts of the peripheral blood showed no quantitative or qualitative alteration of platelets, leucocytes, or erythrocytes in 66 patients studied by Livingood and colleagues;[11] however, bone marrow studies in 16 patients showed some megakaryocyte depression, not accompanied by changes in the peripheral blood, in four patients who had some marrow hypoplasia before treatment with griseofulvin.

SUMMARY

1. Griseofulvin (Fulvicin®), 1 to 0.5 Gram daily, was administered for two weeks to seven months to 101 patients with superficial fungous diseases and experimentally to ten patients with psoriasis.

2. Cure or significant improvement occurred in 35 of 45 patients with *tinea pedis,* in 15 of 17 patients with *tinea manuum,* in 22 of 27 patients with *tinea unguium,* in four patients with *tinea cruris,* in three patients with *tinea corporis,* and in five patients with *tinea capitis.* A presumably adequate duration of therapy failed to improve or permanently cure the other 17 of these 101 patients. The ten patients with *psoriasis* were not benefited.

3. There were 24 slight and temporary side effects in 17 of the 111 patients.

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Combined Intra-Uterine and Extra-Uterine Pregnancy

Report of a Case

Combined intra- and extra-uterine pregnancy is said to be rare, but must always be considered in the diagnosis of complications following abortion.

Combined intra- and extra-uterine pregnancies are not as uncommon as might be imagined. The most recent tabulation (by Winer, *et al.*[1]) records 466 cases. It is the purpose of this report to emphasize further the problem of pre-operative diagnosis, which persists as a serious challenge, and to depict the elusive nature of the entity as well as the maternal hazards involved.

FIRST HOSPITAL ADMISSION

The patient, a 36-year old para 2, gravida 3, was referred to the Middlesex General Hospital in New Brunswick, as a threatened early abortion. Presenting complaint was inability to void spontaneously. The family physician had catheterized her in his office with the release of 1100 cubic centimeters of normal urine. Her last menstrual period was 3 months before admission. Brown vaginal bleeding began two weeks before admission. This required one pad per day, and continued to admission. Her general health was good. There was no previous surgery. Interference with the current pregnancy was denied. Two previous pregnancies terminated in 1945 and 1955 with normal full term living infants.

She was a well developed, well nourished apprehensive woman with evident dark red vaginal bleeding. Temperature was 100.4; pulse 84; blood pressure 128/76. Pertinent findings were confined to the abdomen and pelvis. There was direct and rebound tenderness suprapubically. No masses were palpable. On pelvic examination the cervix was posterior, soft, with a patulous external os. A soft, tender uterus of 2½ months' gestational size lay anteriorly. There were no adnexal masses. The diagnostic impression was infected threatened early abortion. The leucocyte count was 16,000 cells with 92 per cent polymorphonuclear neutrophils and 8 per cent lymphocytes. Hemoglobin was 12 Grams.

She continued to complain of inability to void. This exceeded any abdominal discomfort. Vaginal bleeding persisted. She aborted the following day. Curettage of the uterus yielded large fragments of foul smelling placental tissue. The pathologist reported "necrotic placental tissue infiltrated with much purulent exudate and hemorrhage."

Postoperatively, she did well. She voided spontaneously without difficulty. Antibiotics were given. A low grade fever subsided and the abdominal signs cleared. She was discharged on the fourth day.

SECOND HOSPITAL ADMISSION

The patient was readmitted two weeks after the first admission because of severe abdominal pain. This had begun one week following her return home. Abdominal examination at this time revealed slight lower abdominal distention with muscle "guarding" and direct and rebound tenderness in both lower quadrants. Pelvic examination disclosed bilateral markedly tender, oval, cystic masses extending from the adnexal regions down to the culdesac with the uterus elevated high anteriorly.

1. Winer, A. E., Bergman, M. D. and Fields, C.: Am. Journ. Obst. and Gynec., 74:170 (July) 1957.

There was exquisite tenderness on cervical motion. Recto-vagino-abdominal examination was confirmatory. Leucocyte count was 13,100 cells with 89 per cent polymorphonuclear neutrophils and 11 per cent lymphocytes. Hemoglobin was 10 Grams; hematocrit was 30 per cent.

Within four days, she exhibited a remarkable response to treatment consisting of combined chloramphenicol and sulfisoxazole and 1000 cubic centimeters whole blood transfusion. The temperature, which had varied between 100 and 101, dropped to normal. The abdominal pain and tenderness disappeared. The pelvic masses were reduced to half their original size. She was discharged on home convalescent care with continued antibiotic therapy after one week's hospitalization.



Abdominal pregnancy and uterine specimen.

THIRD ADMISSION

Five days after her recent discharge, and one month from her original entry, the patient was readmitted in a state of shock. She had done well at home for four days. Then she suddenly vomited and collapsed.

Examination showed a pale, perspiring, apprehensive patient. Blood pressure was 86/70; pulse 100; temperature 98. The abdomen was markedly tender and tensely distended. Pelvic examination revealed marked fullness in all fornices with a tender, firm, closed cervix. The diagnostic impression lay between ruptured pyosalpinx and ectopic pregnancy. Total leucocyte count now was 30,900 with 88 per cent neutrophils; hemoglobin, 10.5 Grams; hematocrit, 35.5 per cent.

The patient was transferred to the operating room where whole blood was pressure-transfused simultaneously with laparotomy. The peritoneal cavity contained two liters of liquid blood plus clots. A tense, cystic, pearly gray mass obscured the pelvis. The left fallopian tube and round ligament could be identified coursing across the antero-inferior aspect of this mass. A three-months' size fetus burst into view quickly followed by placenta and membranes (see figure). The placenta had been attached to the posterior surface of the left broad ligament and uterus, the culdesac, and the sigmoid. The right fallopian tube was enlarged, distended, bulbous and sealed off separately from the ovary. The left ovary could not be separately identified. The patient's condition rapidly improved after the administration of 2,500 cubic centimeters of whole blood, permitting total hysterectomy, left salpingo-oophorectomy and right salpingectomy.

Postoperative course was uneventful until the fifth day when she showed a daily spiking temperature to 101, together with left posterior chest pain. Crepitant rales were heard in the left lower posterior lung field. There were no "leg" signs. X-ray of the chest suggested a mild pneumonitis. The medical consultant's opinion was multiple pulmonary emboli without infarction; therefore, anticoagulant therapy supplemented antibiotics. The fever subsided and the chest cleared after four days. The patient was discharged on the thirteenth postoperative day with a well healed abdominal incision.

The pathologist reported a fetus measuring 8.5 centimeters in length with no external abnormalities. The placenta and cord were normal in appearance corresponding to development. Placentation to the outer wall of left fallopian tube and ovary was confirmed. The right tube was described as thickened, dilated and sealed at the end but without evidence of suppuration.

This case followed the typical treacherous course of the undiagnosed combined pregnancy of the type heralded by abortion of the intrauterine gestation. In most of the reported cases, the ectopic pregnancy is fortunately dealt with first, thereby disposing of the greater maternal threat.

Analysis of this report falls into three parts correlative with the hospital admissions.

On the first admission the infected abortion masked any signs of an extra-uterine pregnancy; nor were there any premonitory signs indicating establishment of an abdominal pregnancy. Apparently the second of the two simultaneously fertilized ova digressed for presumptive implantation on the posterior surface of the left broad ligament. The presenting complaint of inability to void spontaneously eludes explanation. The literature does not mention this symptom in ectopic pregnancy. As a matter of interest this same complaint was observed again in a patient later found to have an old, organizing ruptured tubal pregnancy.

The second admission fulfilled the diagnosis of postabortal infection with recovery of the patient following therapy completing the false picture. In this respect the clinical course

resembled experiences reported by Gelb[2] and Horner.[3] In retrospect the pelvic masses actually represented the abdominal pregnancy with partial placental separation (probably from the sigmoid) together with a pelvic hematocele. The resolution must have been due to cessation of bleeding and resorption of the blood.

The third admission provided the dramatic denouement: detachment of the abdominal pregnancy with massive intraperitoneal hemorrhage. Fortunately, active bleeding was confined to the internal genitalia rather than bowel so that hemostasis could be readily secured by their removal. The gamut of maternal perils was pointedly illustrated, indicating the need for improvement in pre-operative diagnosis, correctly made in only 7 out of 71 cases, as reported by Winer.[1]

2. Gelb, R. H.: Canadian M. A. J., 80:279 (Feb. 15) 1959.

3. Horner, H.: California Med., 88:445 (June) 1958.

SUMMARY

1. A case of combined intra- and extra-uterine pregnancy is presented.

2. The extra-uterine component was an abdominal pregnancy.

3. Abortion of the intra-uterine pregnancy masked recognition of the ectopic gestation.

4. Maternal dangers described support the need for improvement in pre-operative diagnosis.

5. Ectopic pregnancy should be considered in the differential diagnosis of postabortal complications.

51 Bayard Street

Birth Order and Schizophrenia

Evidence indicating a relationship between mental disease and order of birth was reported in the January 1961 Archives of General Psychiatry in a study by Carmi Schooler, Ph.D. It was based on a random group of schizophrenics at Springfield State Hospital in Maryland, divided into the older half and the younger half to determine if more patients fell into the first half of their sibling group or the last half. Two-thirds of the patients were in the younger half.

The question of relationship between birth order and schizophrenia has been revived by recently published experimental findings with normals. These studies suggest a relationship between birth order and social self-isolation. First-borns and only children tend to be more affiliative in an anxiety-provoking experimental situation than those who have older siblings. Later-born subjects when anxious did not particularly wish to be with other people.

Dr. Schooler reviewed other studies on birth order and schizophrenia, pointing out that evidence of a relationship is "especially strong when first-born and last-born are compared."

Significantly more of the subjects are last-born than first-born. This difference, however, appears to be entirely due to subjects from families of four or more. One hypothesis is that the apparent effect of birth order is merely an artifact of the relationship between increasing mother's age and incidence of schizophrenia. Also, parents may represent for the young child the only significant social source of anxiety reduction, sibs having no such effect. First-born and first-half children, in general, have greater access to their parents than last-born and last-half sibs, whose parents have a proportionately greater number of other children for whom to care.

Thus, compared with last-born and last-half children, first-born and first-half children may have been more successful in their early attemps to alleviate anxiety through social means.

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Restoration of Hearing in Deafness Due to Otosclerosis

The family doctor's role in understanding and guiding the treatment of otosclerosis is compactly presented in this brief paper.

Otosclerosis is more prevalent than is commonly realized. The incidence of otosclerosis in the general population[1] is 4 per cent. Half of these patients have active lesions that will produce impairment of hearing during the third and fourth decades. This must mean that 3,500,000 Americans will develop this type of deafness between the ages of 20 and 40 years, the prime of their life. Because of revolutionary advances in the technics of ear surgery, useful hearing can be restored to most of these patients. In the series presented here, socially adequate hearing was obtained, and sustained, in 92 per cent of the cases.

The onset of otosclerosis is insidious. The patient, not realizing at first that his hearing is diminishing, blames his difficulty on a cold or noisy environment. Or he thinks that people are mumbling. The hearing continues to decrease. When it reaches the 30 decibel level, the patient realizes that he has definite impairment of hearing. Many of these people do not go to the family physician for advice. Instead, they buy a hearing aid and the case is closed as far as the patient is concerned.

Any patient wearing a hearing aid who comes to the doctor, *for any reason*, should be asked whether he has had an otolaryngologic examination within the last three years. If not, it is the duty of the physician to advise the patient to do so.

The family physician can give intelligent advice by obtaining a short history and performing a few simple tests. To do this effectively, it is necessary to understand the basic pathologic physiology of otosclerosis. Normally, sound waves strike the tympanic membrane, producing vibrations which are transmitted through the ossicular chain to the inner ear. Here sound is perceived by the organ of Corti and transmitted to the central nervous system. This is hearing by *air conduction*. In otosclerosis, the footplate of the stapes becomes slowly fixed to the rim of the oval window by the growth of abnormal otosclerotic bone. This limits its vibratory ability, first to low pitched sounds; and, as it becomes more solidly fixed, to high pitched sounds. If sound is applied to the *bone* of the mastoid region, the vibrations are transmitted directly to the inner ear, thus by-passing the ossicular chain and any defects it may have. This is hearing by *bone conduction*, and it is usually normal in otosclerosis except in very advanced cases. The pathologic process does not affect the tympanic membrane which appears normal to inspection.

1. Guild, S. R.: Annals of Otol. Rhin. & Laryngol., 56:368 (1947).

CLINICAL HISTORY

Otosclerosis tends to run in families, but may manifest itself as an isolated case. It is twice as frequent in females, and is aggravated by pregnancy. It is usually accompanied by a persistent tinnitus, although this symptom may be absent in early cases. In church, patients have difficulty in hearing the preacher. At home, they turn up the television set to a level uncomfortable for the rest of the family. In a noisy environment where people talk loudly, they can hear conversation better than in quiet places where conversation is carried on at normal levels. Eventually, because of embarrassment, the patient withdraws from his usual social activities, and becomes tense and chronically tired from the constant straining to hear conversation.

THE EXAMINATION

Besides the otoscope, the only instrument required is a tuning fork, of 512 vibrations per second. On otoscopy, the canal and tympanic membrane are normal. Wax obstructing the canal is removed. Hearing by *air* conduction is then compared to hearing by *bone* conduction. It is the *comparison* of these ways of hearing that is important. The fork is struck lightly upon the knee and is then placed about one inch from the external auditory meatus. The tuning fork should be held upright with both prongs in line with the general direction of the canal. The patient is asked if he hears it. While the fork is still vibrating, the handle is placed against the mastoid region. Again the patient is asked whether he hears it. Is it louder or softer than by air? The test is repeated until a definite answer is given. In otosclerosis (or any other type of conductive deafness) the patient will hear better by bone than by air.

These patients can be helped! Do not test ability to hear a pocket watch. This can be misleading, as the tick is in the middle or high frequencies where hearing can still be good even if the low frequencies have already been affected.

If bone conduction is better than air conduction, in a young adult with normal tympanic membranes, deafness is probably due to otosclerosis.

SURGICAL TREATMENT

The first practical operation designed to restore hearing was developed by Lempert[2] in 1938: the well known fenestration of the lateral semicircular canal. It was a good operation, although it had many shortcomings. In 1955 Rosen[3] stimulated a great deal of research when he published his cases of stapes mobilization. This operation, however, fell short of expectation, for most of the stapes refixed in the end. In 1958, Shea[4] reported a revolutionary technic: stapedectomy and vein graft over the oval window. As this method has become refined, the incidence of successful results has steadily increased. We now can confidently say that this is, by far, the best operation that we have ever had for the restoration of hearing in otosclerosis.

The operation is usually done under local anesthesia with heavy sedation. It is performed under an operating microscope, with specially designed "micro" instruments that can be inserted through the external auditory canal. The tympanic membrane is lifted and the bony canal curetted to obtain a good exposure of the region of the stapes. The crura of the stapes are removed as well as the mucosa surrounding the oval window. This creates a bed for the vein graft. The vein, about 7½ millimeters in length, is taken from the dorsum of the hand. The adventitia is removed and the vein split longitudinally, thus obtaining a very thin, rectangular graft. The footplate of the stapes is then removed under high magnification. Occasionally the otosclerotic bone has to be thinned down with a tiny, electrically driven burr before it can be removed. The segment of vein is then positioned over the oval window and a piece of poly-

2. Lempert, J.: Archives of Otolaryng., 28:42 (1938).
3. Rosen, S.: New York State Journal of Medicine, 53:2650 (1953).
4. Laryngoscope, 66:729 (1958).

ethylene tubing is placed between the incus and the vein graft. The patient may be dizzy for one or two days, and is usually discharged on the fourth or fifth day. For the next six to eight weeks following surgery, hearing continues to improve as the edema subsides.

COMPLICATIONS

IN ABOUT one per cent of the cases, hearing diminishes following the operation, due probably, to operative trauma. Sometimes, although a technically perfect procedure has been done, the hearing does not improve. There are several reasons for this, but in general it means that the pathology was not restricted to the stapes region. Infection of the middle ear can occur in the early postoperative period in spite of a strict aseptic technic and coverage with antibiotics. This has happened in two of our cases. Even in these cases, hearing improvement was not affected, indicative of how quickly the vein graft seals over the oval window. More frequently, the external canal may become infected, but this is a minor problem.

RESULTS

IN OUR last 100 cases, socially adequate hearing was obtained in 92. In one case, hearing diminished following surgery, and in 7 hearing did *not* improve to a socially adequate level (30 decibels or better) or did not improve at all.

SUMMARY

1. Today the most common cause of deafness in the young American adult is otosclerosis. Over 90 per cent of these patients may be restored to a normal hearing life through modern otologic surgery.

2. A simple test that the family physician can perform in his office, and the salient points in the clinical history of the disease are discussed.

3. A series consisting of the last 100 cases operated upon by us is presented, with restoration of adequate hearing in 92 per cent.

601 Grand Avenue

Divorced People Are Sicker

Zeva LaHorgue in the 1960 Journal of Chronic Diseases (12:476) makes the following report on absenteeism and marital status. Higher rates of illness are found among divorcees. Weekly interviews were conducted with 30,000 people, representative of the California population in illness, population characteristics and medical care. Ages ranged from 25 through 74.

In California the proportion of married and widowed persons is the same as in the rest of the United States; *the proportion of divorced people is about twice as high* and the proportion of never-married people lower.

The major difference between married and divorced people was found in the chronic disease group. The days of disability per person per year from chronic disease were twice as many in divorced as in married men. More limitation of activity was observed in divorced people, as was higher incidence of more than one chronic illness in one person. Hospital admissions were more frequent and lasted longer in divorced than in married people (if deliveries were excluded).

Health insurance coverage was found more often among married people than among the divorced.

The highest percentage of divorces was found among the lowest income group (under two thousand dollars a year), and in this group disease was most frequent. It is not clear from the statistics whether disease is the result of poverty or poverty the result of disease.

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Office Management of Peripheral Circulatory Disturbances*

Practitioners often forget that the cardiovascular system includes the peripheral vessels too In this compact monograph, Dr. Redisch offers usable guide-lines to the practitioners.

Cardiovascular disease accounts for a high percentage of mortality, morbidity and permanent disability all over the world. It is particularly prevalent in countries with a high standard of living. Small wonder then that we have an appallingly high number of cases in this country. This applies to diseases of the peripheral blood vessels as well as to those of the heart and the large central vessels. Indeed, it would be more appropriate to abandon the term "peripheral vascular disease" and to speak instead of "peripheral manifestations of vascular disease."

The practitioner, faced with a peripheral vascular problem has first to be aware of the fact, that (apart from *intrinsic* vascular disease) there are various *extrinsic* factors which may produce alterations in blood flow.[1]

1. Traumatic injuries
2. Diseases of or injury to the nervous system
3. Disturbances in the endocrine system
4. Changes in general circulation
5. Abnormalities of the musculo-skeletal system
6. Changes in the composition of the blood
7. Sensitivity reactions

Next, he has to recognize conditions which might simulate peripheral vascular insufficiency in the absence of intrinsic vascular disease.[2]

1. Myocardial failure
2. Mitral stenosis with small left ventricle
3. Dehydration
4. Arterial hypotension
5. Shock
6. Coarctation of the aorta
7. Ball-valve thrombus in the left atrium
8. Aortic stenosis
9. Anemia or other hematologic disorders

Once he is convinced that he is dealing with intrinsic vascular disease, his task is to try to recognize the *type* of blood flow disturbance. It is more important to do this than to find a label for the condition.[2]

The vascular tree may be divided into three segments: the arterial, the venous and the minute vasculature. The latter component is usually called "capillary," though it includes in addition to the true capillaries the arterioles, the pre-capillary plexuses, the post capillary plexuses and the venules. Frequently, two or all of the three segments may be involved in a case.

The following tabulations show the types of disturbances in blood flow which result from lesions in each segment, as well as the clinical

*Read by invitation, December 1, 1960, to the Graduate Program, Seton Hall College of Medicine, Jersey City, N. J. Dr. Redisch is Associate Professor of Medicine at New York University.

1. Allen, E. V., Barker, N. W. and Hines, E. H. Jr.: *Peripheral Vascular Diseases.* Philadelphia, 1955. Saunders.

2. Redisch, W., Tangco, F. F. and Saunders, R.: Peripheral Circulation in Health and Disease. New York, 1957. Grune and Stratton.

symptomatology they produce and their resulting pathology.

I. ARTERIAL SEGMENT

A. ACUTE (Embolus, thrombus, spasm)

1. Pallor—with or without mottling
2. Pain—sometimes relieved on dependency
3. Coldness
4. Numbness

a. With later gangrene
b. With spontaneous recovery

B. CHRONIC (Thrombus or proliferative obliteration)

1. Postural color changes
2. Coolness in the extremity
3. Pain on effort

a. Intermittent claudication
b. Pain during rest, relieved on dependency

4. Secondary neuritis

a. Arterial insufficiency
b. Isehemic symptoms—such as gangrene ulcer

II. VENOUS SEGMENT

A. ACUTE

1. Rubor with cyanosis
2. Pain relieved on elevation
3. Pitting edema

a. With gangrene (rare)
b. Complete with spontaneous recovery and canalization
c. Incomplete recovery with persistent venous insufficiency

B. CHRONIC

1. Cyanosis with or without pallor
2. Moderate pain relieved on elevation
3. Swelling either

a. With some pitting or
b. Entirely "brawny"

4. Venous insufficiency

III. MINUTE VESSEL SEGMENT

A. ACUTE

1. Exanthemata and enanthemata. Toxic wall damage. Capillary embolization.

a. With complete recovery
b. Necrotizing lesions with scar formation

2. Acute thermal injuries

a. Burns. Capillary regeneration through grafting
b. Acute frostbite
c. Acute "trench-foot," with distal gangrene (rare)
d. Acute "trench-foot," with chronic regulatory disturbance and sensitivity to heat or cold

B. CHRONIC

1. Telangiectasis
2. Vascular tumors
3. Regulatory disturbance with sensitivity to cold. Raynaud's phenomenon. Chilblains.
4. Regulatory disturbance with sensitivity to heat. Erythromelalgia.
5. Regulatory disturbance with sensitivity to any temperature change. "Chronic trench-foot."

In most cases, the practitioner will be able to evaluate the situation in his office. Some may require arteriography, plethysmography, venography or other more complicated methods. These patients should be hospitalized. Oscillometry can be readily done in the office. This should be looked upon as essentially a *confirmatory* method, as a help in cases where there may be doubt about location of pulsations or differences in comparing right and left limbs. Other special technics may require operating room facilities or a "circulation laboratory." These methods are all hospital, not office, procedures.

In managing a case of disturbed peripheral blood flow, the physician may have to make a decision about restorative surgery. Such surgery is now available for the major predilectional sites of occlusive arterial disease. Tabulated below is a schema of the possibilities for improving arterial flow.

I. RESTORATION OF PRIMARY CIRCULATION

1. Spontaneous with canalization of thrombus
2. Surgical—requiring an operative procedure
3. Medical—affording relief of arterial spasm

II. DEVELOPMENT OF COLLATERAL CIRCULATION

1. Spontaneous
2. Surgical—sympathectomy
3. Medical—interference with vasoconstrictor impulses

For the chronic arterial insufficiency patient who remains in office care, a vascular routine is still the basis of management. Here are the instructions we give:

1. Keep extremities dry and warm.
2. Avoid injuries. If injuries occur, report immediately to the doctor.
3. Use wide, firm shoes, allowing for as many pairs of woolen socks as necessary.
4. Do not smoke.
5. Take three ounces of scotch whisky, bourbon or brandy, each day.
6. Reflex vasodilation by body warming, once or twice one hour every day.
7. Graded exercise (walking on even plane): or, if the patient is bed-ridden,
8. Buerger's exercises; or if the patient is too ill for this,
9. Saunders' vasoscillating bed.

To point 4 should be added, that good evidence has been presented recently showing that all persons whose skin is sensitive to tobacco extracts manifest a decrease in skin blood flow after smoking. The overwhelming majority of subjects with negative skin tests fail to show this vascular response. Responses in muscle flow have been inconclusive. Thus, screening of patients with vascular disease by skin testing for tobacco sensitivity may be of considerable practical value.[3]

Drugs may be of help in well-selected cases. Interference with vasoconstrictor impulses from the internal environment by adrenergic blocking agents (Dibenzyline®, Ilidar®) aid especially skin and resting muscle flow, some adrenaline-related agents (Arlidin®, Vasodilan®) increase blood flow to the working muscle.

All these drugs have side-effects and the physician must familiarize himself thoroughly with the contra-indications.

The management of deep venous disease has changed since the availability of fairly well controllable anticoagulants. To put it in a nutshell: the indications for venous ligation are by now identical with the contra-indications to anticoagulation.

These contra-indications are:

1. All hemorrhagic states and blood dyscrasias
2. History of bleeding
3. Advanced liver disease
4. Ulcerations in the gastro-intestinal tract
5. Very advanced kidney disease
6. Behavioral difficulties (chronic alcoholism and the like)

Whenever venous ligation for thromboembolic disease is unavoidable, vena cava inferior ligation is, as a rule, the method of choice. Still very useful are such time-honored methods as elevation of the foot of the bed, and, in ambulatory cases, the use of elastic supports.

Varicosities even when thrombosed are *never* the origin of pulmonary embolization.

We can do little directly about minute vessel disease. More often than not this is a manifestation of some other systemic disorder as shown in the table.

Acrocyanosis, cutis marmorata and livedo reticularis are vasomotor disturbances which, *per se*, have no clinical significance and do not call for treatment.

Raynaud's disease is managed with adrenergic blockage and sympathectomy. It is characterized by severe sensitivity to cold, the development of small ulcerations at the acra and acrosclerosis. It is related to sclerodoma, but the connection is still obscure.

In contrast, *Raynaud's phenomenon* (unless associated with Raynaud's disease) is not a vascular disease, but a regulatory disturbance, mostly on a psychogenic basis. So is causalgia, unless it is associated with reflex dystrophy of the extremity. The classical example of reflex dystrophy of an extremity, always associated with causalgia, is that following peripheral nerve injury. However, it occurs after myocardial infarction[2] and in old rheumatic heart disease.[3] It may be related to disuse, but is obviously triggered by dysfunction of the sympathetic innervation. Prevention by avoiding disuse and treatment with paravertebral blocks are recommended.[4]

True physical hypersensitivity to cold with painful giant urticarial edema, limited to the exposed parts, is rare; antihistaminics are effective prophylactically as well as therapeutically. *Erythromelalgia*, the manifestation of

3. Redisch, W., Meckeler, K., Brown, W. and Steele, J. M.: Annals of the New York Academy of Sciences, 90:142 (1960).

4. De Takats, G.: Archives of Surgery, 34:939 (1937).

physical hypersensitivity to heat, appears in the form of painful red and hot swelling on the exposed parts. It may lead to small ulceration and responds temporarily to cooling and aspirin.[1] Some respond permanently to histamine-desensitization. The first table below lists some underlying conditions associated with vascular manifestations, in the order of frequency, and their management. The next table summarizes the related extravascular conditions and their management, again in the order of frequency.

DISTURBANCES IN PERIPHERAL CIRCULATION

UNDERLYING CONDITIONS AND THEIR MANAGEMENT

Condition	Management
Atherosclerosis	1. Keep body weight 10% below standard 2. Restrict fat intake 3. Encourage graded exercise 4. Long term anticoagulation (?)
Diabetes mellitus	1. Control diabetes 2. Avoid "ups and downs"
"Collagen" diseases	1. Corticosteroids 2. Antimalarial drugs (?)
Luetic endarteritis	Penicillin
Tuberculous arteritis	Streptomycin — PAS — Isoniacin
Toxic endarteritis (e.g. ergot)	Discontinuation of toxin

DISTURBANCES IN PERIPHERAL CIRCULATION

RELATED EXTRAVASCULAR CONDITIONS AND THEIR MANAGEMENT

Condition	Management
CNS—lesions	1. Papaverin 2. Long term anticoagulation 3. Cervical sympathectomy (?)
Heart disease	1. Keep out of failure 2. Long term anticoagulation 3. Cardiac surgery 4. Treatment of SBE and rheumatic fever
Anemias	1. Transfusions 2. Pernicious An.: Liver B_{12} 3. Gravidity An.: Folic acid 4. Sec. (Hypochronic) An.: Iron 5. Hemolytic An.: Corticosteroids
Leukemias	1. Transfusions 2. Irradiation 3. Acute L.—Folic acid antagonist, nitrogen mustard, TEM 4. Chronic lymphatic L.—Mercaptens, Nitrogen mustard; p^{32} 5. Chronic myeloic L.—Myleran
Thrombocytopenic purpura	Splenectomy
Polycythemia	Repeated venesections and p^{32}
Intra-abdominal malignancies	Surgery or irradiation

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The School Physician's Role in New Jersey

In the first survey of its kind, the authors spotlight some imperfections in the practices of school physicians and suggest possible corrective.

The school physician, like the private practitioner, is concerned with the health of school children. How do their roles and methods differ? What are the school physician's peculiar responsibilities? What contribution should he and can he make to the general welfare of his community?

In most New Jersey communities, the school physician is engaged on a part-time basis. This is desirable from the practitioner's point of view, and is also necessitated by prevailing views on the extent of the school's responsibility for the health of its pupils. Of course, the school physician who is also in private practice is better able to keep abreast of current medical thought. More basic, however, is the belief that primary responsibility devolves on the parents for individual, private medical care for their children.

The school physician acts as an "arm" of the local school system in the detection of disease among school-age children for definitive diagnosis and eventual treatment by the family physician. Thus, in his "guidance" role the school physician should see that each child is examined at frequent intervals, preferably by the private physician.

Furthermore, the school physician is responsible for contagious disease case-finding, including the detection of tuberculosis. He should be in constant contact with parents, private practitioners, and public health officials to maintain an effective liaison. He should give advice on the establishment of immunization programs in the schools. He may conduct sanitary inspection of school facilities, counsel for athletic activities, and keep medical records.

Survey of School Physicians

A questionnaire was sent at random to 150 school physicians in New Jersey. The aim of the survey was to determine how school physicians in our state appraised and supervised the health problems of children in their districts. There were 94 replies.

1. *How often does the school physician examine the children in the school district?*

Of the 94 replies, 29 school physicians (31 per cent) conduct an annual examination; 15 (16 per cent) examine every two years; 44 (47 per cent) every three years; and 6 (6 per cent) every four years. Four stated that they encouraged the parents to have the children examined privately.

2. *What is the child's state of attire during the examination?*

Thirty-six physicians (39 per cent) replied that the children are *not* undressed; 50 replies (53 per cent) describe a "stripped to the waist" examination; 8 physicians have the children completely undressed except for underpants. This last group did not include secondary school children. It should be noted at this point that according to New Jersey law,[1] ". . . the medical inspector may require pupils to loosen, open, or remove their clothing above the waist in a manner to facilitate inspection and examination; provided, in any such case the parents or guardians shall be notified in writing of such proposed examination and in such notice the presence of one of the parents or guardians shall be requested . ."

3. *What systems are included in the examination?*

Neurologic examination was included by only 16 physicians (17 per cent). Almost all physicians examined the heart, lungs, head, neck, skin, and general development. Systems examined were as follows:

	Number	*Per Cent*
Eyes, ears, nose, and throat	87	(92)
Head and neck	91	(97)
Lungs and heart	93	(99)
Abdomen	44	(47)
Genitals†	36	(38)
Neurologic	16	(17)
Skeletal	67	(71)
Skin	89	(95)
Nutrition	84	(89)
General development	89	(95)

†All examinations were of male children only.

4. *What is the frequency of testing of vision?*

Apparently, in most districts, vision examinations are made by the school nurse with a Snellen chart or its equivalent. Defects are then reported to the school physician who advises accordingly. In two school districts, optometrists test vision. The examination is done:

Yearly by 77 districts replying	(82 per cent)
Every two years in 11 districts	(12 per cent)
Every three years in 4 districts	(4 per cent)
"As indicated" in 2 districts	

5. *What is the frequency of hearing examinations?*

Most districts use an audiometer. Hearing tests are conducted:

	Per Cent
Yearly in 45 districts replying	(48)
Every two years in 19 districts	(20)
Every three years in 20 districts	(21)
Every four years in 1 district	(1)
"As indicated" in 9 districts	(10)

6. *What is the frequency of tuberculosis testing in the elementary grades?*

Annual tuberculosis testing is required by New Jersey law on children in the secondary schools.[2] However, testing is *not* mandatory in kindergarten and the first eight grades. In 47 of the 94 school districts surveyed, tuberculosis testing is *never* done in the elementary grades. It is performed:

Annually in 8 districts replying	
Every two years in 2 districts	
Every three years in 15 districts	
Every four years in 9 districts	
Once only in 3 districts	
"As indicated" in 10 districts	

The prevalence of the disease in various locales often influences the frequency of testing. It seems incongruous though, that in the majority of school districts there is no testing in the elementary grades, while annual testing is mandatory in the secondary grades.

7. *What immunizations are mandatory?*

Diphtheria immunization is required for entrance in 74 of the 94 districts; smallpox immunization is required in 86 districts (92 per cent) and poliomyelitis immunization is required in 64 districts (68 per cent). Many districts in which these immunizations are not mandatory report that they are "encouraged," and that there is a high ratio of voluntary cooperation by parents.

1. N. J. Statute 18:14-57.1.
2. N. J. Statute 18:14-64.5.

8. *What part of the school physician's time is consumed by routine physical examinations; special examinations; counseling; teaching; lecturing; clerical work; and other tasks?*

About half of those who replied to the questionnaire did not answer this question. Most of the remainder gave a figure between 85 and 100 per cent for "routine" physical examinations; only a few gave figures for the other categories.

Many authorities[3] feel that the abilities of the school physician are not fully utilized. This is borne out by this survey. Routine physical examinations are really not very valuable in finding disease and handicaps. Most physical examinations are inadequate because of the number to be performed in a limited period of time. In most cases only scanty histories are obtained. When the children are not undressed (as is the case in over one-third of the school districts) a reasonably thorough examination cannot be given. Finally, if these examinations occupy almost all of the school physician's time he has little or no time for health education programs, counseling, maintaining liaison with parents and family physicians, and the numerous other tasks expected of him.

The major obstacle in the school physician's path seems to be the inflexible school laws which prevent him from changing his present routines. Under existing statutes it is difficult to encourage the examination of school children by their private physicians. Any child who is not examined privately must be examined at school periodically even though the family may be in excellent financial circumstances. It is even difficult to open the child's shirt at school because of statutory limitations. There is no uniform tuberculosis case-finding law for elementary grades. As a result there is no attempt at case-finding in most of the school districts surveyed despite the fact that all secondary school students are tested annually.

The medical community in New Jersey is becoming more and more aware of the need for revision and modernization of our school health programs, with special attention to the role of the school physician. However, the school physician will be able to fulfill his role in the community only with the aid of additional legislation.

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CONCLUSIONS AND SUMMARY

A QUESTIONNAIRE was sent to a random sampling of school districts in New Jersey to inquire about the current role of the school physician. It was determined that the school physician's abilities were not fully utilized because of the pressure to do "routine," but inefficient, physical examinations. Corrective legislation is needed to help the school physician in his educational and advisory tasks.

22 Washington Avenue

Fifty Years of School Health Cooperation

This month marks the golden anniversary of cooperation between the AMA and the National Education Association in promoting school health. It was commemorated by a symposium. The program began in 1911 when Dr. Thomas D. Wood, professor of Physical Education at Columbia University persuaded both professional organizations (NEA and AMA) to develop committees on school health. Each parent organization is now represented by five appointees.

Activities of this Joint Committee include the publication of books and pamphlets; leadership in school health practices; developing and testing of new ideas; education of legislators, teachers, physicians and the public. An interesting feature of the anniversary ceremony was the presentation (in 1961) of five papers based on the topics used at the "medical evening" of the National Education Association in 1912. Another feature of the celebration was the presentation of a citation from the National Tuberculosis Association accolading the Joint Committee and the parent organizations for their initiative and leadership in the field of child health.

C. M. B. Gilman, M.D.

Red Bank

Control of Anginal Pain with Nialamide

Report of a Case

Anginal pain keeps the cycle going. Anticipation of pain leads to anxiety; anxiety aggravates the angina. Anything to cut this vicious cycle is welcome. By ameliorating this pain, nialamide may serve this purpose.

The monamine oxidase inhibitors are now widely used for their psychic stimulating effect in the treatment of depressions. They have an additional and apparently, unrelated effect in relieving pain, especially anginal pain. Nialamide has been found particularly suitable for this because it appears to be the safest of the monamine oxidase inhibitors, as well as one of the most effective. Several reports attest to these facts.

A number of theories (none completely satisfactory) have been advanced to explain the mechanism of this drug. It has neither been proved nor disproved that nialamide has an effect on the myocardium or coronary circulation. It is generally postulated that the drug acts by blocking pain conduction, presumably in the central nervous system. This purely symptomatic relief is of major importance because the elimination of anginal pain is a great step in the control of angina pectoris, and with it the feeling of impending death and the dread of future attacks. With such symptomatic improvement patients tend to become more active. One authority with considerable experience says that there is no harm in this. He states that he has seen no untoward episodes. Patients must, however, be warned against undue activity and not be lulled into a false sense of security. The essential cardiac pathology is, after all, unchanged by nialamide. The papers cited below, present an impressive array of good-to-excellent results with nialamide. They do not go into much detail. For this reason it may be of interest to report a history illustrating the clinical use of nialamide in angina pectoris.

At the time of the first anginal episode, this 57-year-old, high-pressure New York executive divided his time between his business and his "farm." He worked harder on the farm than at the office. In 1955 he noticed he was short of breath when climbing a short grade. He was advised to lessen his pace. He chose to ignore this, and in November, 1958 entered a New York hospital, complaining of shortness of breath on exertion and of precordial pain radiating to the arms. This pain was relieved within a few minutes by rest. Past history was not remarkable except for removal of the left kidney, twelve years previously, because of congenital malformation. He had had gout, and had recently suffered attacks of furunculosis. At the time of admission he had a nuchal abscess from which Staphylococcus aureus was isolated. It responded to incision, drainage and nitrofurazone. The gout was well controlled by colchicine. The patient stated that his anginal attacks were becoming more frequent, occurring principally at mealtime and at night. They were relieved in the hospital by nitroglycerin and pentaerythritol tetranitrate. The electrocardiogram showed right bundle branch block and evidence of posterior coronary occlusion. Serum cholesterol was high (over 300 milligrams per 100 milliliters) and uric acid was moderately high (6.3 milligrams per 100 milliliters). The attacks were not arrested in the hospital and the patient returned home, to a "nightmare," as

he puts it, of as many as eight attacks a night and five a day. In the ensuing months the anginal attacks increased in frequency and severity despite regular use of coronary vasodilators. In October, 1959 he was admitted to a general hospital in Philadelphia, for further study, treatment, and possible coronary surgery. At this time, x-ray showed 1 per cent enlargement of the left ventricle, and elongation and widening of the aorta.

The electrocardiogram in 1959 confirmed the earlier finding of complete right bundle branch block. T-wave changes in the precordial leads indicated coronary ischemia. There was a Grade I systolic murmur at the apex. Rhonchi were heard over the right lung field and rales at the left base, suggestive of emphysema. The diagnosis was coronary atherosclerosis with angina pectoris. Coronary endarterectomy was considered but was not carried out because of the bundle branch block and because the anginal pain yielded to nitroglycerin. Anticoagulants were not prescribed because the veins were inadequate. The patient was well maintained on a low diet, a tranquilizer, nitroglycerine ointment applied twice daily, and nialamide, 75 milligrams daily. Nitroglycerin, 1/200 grain, was prescribed for the relief of attacks when they occurred, which was not more than three times per day. Before the addition of nialamide, he had had as many as thirteen attacks per day. Pain now recurred only under the stress of undue exercise. Nialamide, however, had no effect on the electrocardiogram.

Six months later the patient was still doing well. He continued to take nialamide, 75 milligrams a day. A diuretic was added temporarily because of a tendency to edema. The patient was able to indulge in moderate activity without the feeling of fatigue, shortness of breath, and frequent episodes of anginal pain, which had not been possible before nialamide was prescribed. In 1960 and 1961, he was able to go to Florida each winter, to sail his boat, to live comfortably and without pain.

Since this first dramatic case, I have seen four other patients with various degrees of coronary and anginal pain. Their response has been excellent. Treatment with nitrates, nitroglycerin ointment, nialamide, bedrest and rarely oxygen has made it possible for all of them to come through and continue useful lives. Of course, they must adjust to a slower pace, reduce mental and physical activities, lose excessive fat (if overweight), eat more slowly, a lighter diet, and chew their food well.

The patient must be "returned to health" slowly, step by step, never approaching tiredness or exhaustion; he must train himself to underdo rather than overdo.

SUMMARY

1. A man of 58 with coronary atherosclerosis and anginal pain was initially well controlled with pentaerythritol tetranitrate and nitroglycerin; but as the disease progressed, the anginal attacks increased in frequency.

2. Addition of nialamide, 75 milligrams a day, allowed the patient to lead a reasonably active life, with episodes of angina occurring only on exertion. This patient is now well and free from pain. Four other cases were treated successfully with nialamide.

Blossom Cove Farm

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Thomas S. P. Fitch, M.D.

Bernard J. Sussman, M.D.

Plainfield

Fibrinolysin in Cerebrovascular Diseases*

New hope for some patients with cerebrovascular disease is offered by the surgical approach here described. Dr. Fitch and Dr. Sussman were probably the first to use fibrinolysin in cerebral vascular disease.

The recent and rapid accomplishments by biologic chemical research in producing a refined and effectual substance called fibrinolysin stimulated immediate attention to its usefulness in cerebrovascular disease. Wright[1] has estimated that 200,000 people die each year from cerebrovascular disease, and that 2,000,000 Americans have suffered strokes which have left them with a neurologic deficit of some degree. Many are totally incapacitated. Others have been enabled by modern rehabilitation, a costly and tedious regime, to re-enter society with some degree of usefulness. The magnitude of the problem is evident.

During the past ten years, anti-coagulant therapy has received much attention in the treatment of cerebrovascular disease. A recent panel[7] revealed several specific contra-indications to its use. Hemorrhage in the cerebrospinal fluid or in the gastro-intestinal tract is the outstanding contra-indication. Severe liver or renal disease and pronounced vascular hypertension, with a blood pressure reading above 230/120 are considered dangerous, since an additional bleeding tendency due to the drugs could promote fatal hemorrhage. Specific candidates for the use of anti-coagulant treatment include patients with rheumatic heart disease, who are fibrillating, and those with concomitant myocardial infarctions.

A still more recent concept in the treatment of cerebrovascular disease is reported by DeBakey, *et al.*[2] They presented 305 patients with manifestations of arterial insufficiency of the cerebrum and upper extremities. Arteriography revealed extracranial occlusion in 122. Of these patients, 106 submitted to operation. Although multiple lesions were present in half of the cases, the prime etiologic factor was arteriosclerosis. DeBakey[2] classified the lesions as proximal and distal. These studies brought out a new concept in revealing the frequency of occlusive and stenotic factors in the carotid and vertebral arteries throughout their course in the neck and in the upper thoracic cavity. They devised bypassing procedures, even carrying plastic transplants to the aorta for carotid stenosis and in vertebral obstructions to the subclavian artery. They carried out end-to-side bypass grafts, as well as endarterectomies. Many of these procedures proved successful. They were careful to control other factors during operation, maintaining blood pressure levels and inhibiting carotid sinus reflexes through procaine injections.

Denny-Brown[3] reports the use of thermocouples and thermisters to record the blood flow in cortical cerebral vessels. In monkeys, he demonstrated a drop in blood pressure and

*From the Muhlenberg Hospital.

blood flow, with reduced oxygen saturation in arterial occlusions. An important observation was the lack of neural deficit, both systemically and histologically in normal animals following experimental arterial occlusion, because of the tremendous efficiency of collateral circulation. His experiment showed the development of venous microstasis affected by other factors, induced by reduced collateral circulation, accompanying anoxia, anemia or low blood pressure. An irreversible reaction occurred in five to fifteen minutes following hemoconcentration and sludging. He states[3] that the cerebral tissue oxygen is consumed within twenty seconds of cessation of blood flow and points out that oxygen transport is the most important function of cerebral circulation. Denny-Brown[3] indicates that "Blood flow is determined by arterial pressure *versus* cerebrovascular resistance." He also showed that experimental spasm of meningeal arterioles occurred when saline was rapidly injected into venules against blood flow, and the resulting endothelial damage by anoxia, sludging and resulting infarction, ended with softening.

THE traditional theory of end arteries in the brain has been shattered by recent research. Anatomic injections by vascular infusions of radio-opaque substances, recent experiments with living blood vessel through stereoscopic microscopy and angiographic observation through serial short-time interval exposures, have all proved the tremendous anastomotic connections of the cerebrovascular system. Recognition of this has an important part in our approach to the problem of cerebrovascular occlusions and insufficiencies. With a change in our concepts, we can understand such statements as that of Hicks and Warren,[4] "More infarcts occur in the absence of thrombosis than in its presence." Narrowing of the lumen of an artery with destruction of its intima causes the formation of a clot. Associated hypotension or heart failure alters the blood flow and precipitates thrombosis.

The administration of fibrinolysin in cerebrovascular disease offers problems quite different from the use of the enzyme directed to other parts of the body. Brain cells are sensitive to anoxia and easily succumb to an irreversible reaction.

Our interest in the use of fibrinolysin began in 1959. We have reported nine cases who had angiographic studies.[5,6] Our experience is limited to Actase®,† which we gave intravenously usually up to 100,000 units daily, in saline solution. Some patients received injections up to 100,000 units directly through the carotid artery supplying the affected hemisphere. No serious deleterious effects were observed. We considered Actase® safe, in spite of the hazards this group of patients presents.

Of the nine cases treated in our report, five died. Hypertensive atherosclerosis was the apparent etiologic factor in five; four suffered from auricular fibrillation. In one patient an endarterectomy was performed on the carotid artery, and the thrombus removed. The vessels showed severe intimal changes with plaque formation. In the post-mortem examination, a hemorrhagic encephalomalacia with pontine hemorrhage was discovered, as well as a reformation of the thrombus in the original segmental thrombosed portion of the carotid artery. Evidence suggesting re-establishment of the occluded lumen appeared in three cases of cerebral embolism and one case of middle cerebral thrombosis. Partial clearing appeared in two more cases of thrombosis. There were three failures.

From our limited material we cannot conclude too much regarding the ideal patient and technics. Young, conscious, hospitalized patients suffering from emboli which have angiographic confirmation appear most favorable for fibrinolysin therapy. Very early administration appears essential. Patients with intermittent symptoms from stenosis would be considered candidates for anti-coagulant therapy or the bypassing procedure.

Fibrinolytic enzyme has been shown to be more or less effectual in causing dissolving in a clot. The beneficial effects on the clinical course of the patient leave much to be desired. The rapidity of irreversible changes in neur-

† Supplied by Ortho Pharmaceutical Laboratory, Raritan, N. J.

one cells makes any therapeutic measures of little value in strokes caused by vascular occlusion. By the time the patient with hemiplegia or other neurologic deficit is hospitalized and evaluated properly, the usefulness of fibrinolysin is gone, except in the unusual case.

Patients with recurrent cerebral insufficiency may best benefit from fibrinolytic treatment in addition to anticoagulant and bypass procedures.

CONCLUSION

EARLY dissolution of a clot before collateral circulation is compromised should be the objective of fibrinolysin therapy. Treatment should be planned to re-establish and maintain adequate circulation to the brain to prevent a catastrophic neural defect resulting in death or severe incapacity. The delicate balance of nourishment to the neurone cells through collateral circulation after the primary blood supply is compromised by stenosis or obstruction remains the paramount problem. Continued angiographic studies to visualize the progress is essential.

A conscious, youthful patient who has suffered a cerebral embolism appears to be the proper subject for fibrinolytic enzyme treatment. Ideally he should be in a hospital where angiographic visualization of the vascular obstruction can be carried out immediately. Early treatment should be started by intravenous injection of fibrinolysin or by additional intra-carotid injection if indicated.

916 Park Avenue

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Hypertension in the Obese

Writing in the 1959 *Circulation* (19:511), H. M. Whyte reports that a study of 100 men, 20 to 40 years of age, showed a positive correlation between blood pressure and body weight, other factors being equal. However, while excess weight is usually fat, the overall bulk, irrespective of whether it is fat or muscle, is the pertinent factor. Applying the results of this study to one individual whose weight is changing, and taking into consideration the increase in arm size* with weight gain, the systolic pressure would be expected to rise by 10 millimeters Hg and diastolic pressure by 7 millimeters Hg with each increment of 28 pounds in body weight.

**It is known that the ordinary method of measuring blood pressure gives readings that are falsely high when the arm is big. The manometer cuff should be 20 per cent wider than the diameter of the arm.*

Trustees' Meeting: February 19, 1961

The Trustees met on February 19, 1961 in the Executive Offices in Trenton. Announcement was made that The Medical Society was invited to appoint a representative to the Planning Committee of the New Jersey Conference on the Handicapped. The immediate purpose is to develop a statewide directory of services for the handicapped.

Action: Dr. Elmer Elias, chairman of the Committee on Rehabilitation, was designated as our Society's representative to this Planning Committee.

The President reported that he had received a letter from the American Medical Education Foundation acknowledging our Society's contribution of $30,000 which was presented at the 1960 session in Washington.

A report was made to the effect that the New Jersey Society of Chiropractors had asked the amendment of Senate Bill 66 to permit school medical examinations by licensed practitioners instead of by licensed physicians.

Action: The Board approved the recommendation of Council disavowing the proposed substitution of the word "practitioner" for "physician" in S-66.

It was reported that our Special Committee on Mental Health had agreed that hospitals which do not provide in-patient care of alcoholics should receive financial assistance for the out-patient treatment of alcoholics provided they did not restrict their admissions because patients were alcoholics but, rather, that they accept those whom they were equipped to treat. The Committee also felt that financial assistance for out-patient alcoholics should be denied the hospitals which refuse to treat in-patient alcoholics.

The Committee also recommended that a psychiatrist should be in charge of the alcohol program, whether it is conducted by the State Department of Health or by the State Department of Institutions and Agencies. There was an amendment to this proposal to the effect that the phrase 'psychiatrist' be deleted and 'licensed doctor of medicine' be substituted.

Action: The recommendation, as amended, was carried.

Dr. Mulligan's term as a member of the State Board of Medical Examiners is expiring and the Governor has requested nominations. The following names were submitted to the Governor: Dr. L. A. Mulligan; Dr. Carl N. Ware; Dr. George W. Grenhart.

Action: The motion recommending these names was submitted to the Governor. We were subsequently notified that Dr. Mulligan was reappointed to the State Board of Medical Examiners.

Notice was received that Dr. Butler had accepted appointment as a member of the Health Scholarship Committee for New Jersey of the National Foundation.

Mildred Gregory: Woman Doctor of the Year

On April 12, the American Medical Women's Association honored Mildred Gregory, M.D., as "Woman of the Year." Born in Newark, Dr. Gregory earned her B.A. at Wellesley and an M.S. at Skidmore. She taught biology and then matriculated at the College of Physicians and Surgeons, Columbia University, from which, in 1928, she received an M.D. degree. After interning at the Newark City Hospital, she accepted a residency in pediatrics at the Babies Hospital in Newark, and then entered private practice. Dr. Gregory served that hospital in many capacities, becoming medical director there in 1949—a position she retained for eight years. She became a Diplomate of the American Board of Pediatrics and has affiliation in that specialty with many hospitals in Northern New Jersey. She is on the Board of the Newark YWCA, and has been active in church, civic and child welfare work in many fields.

Council on Legislation

C. Byron Blaisdell, M.D., Chairman

The Council on Legislation took the following actions concerning legislation of medical interest. Measures marked (*) are identical with bills of last year and are recommended for the same position.

*S-30 Waddington—To require as a condition precedent to a person's obtaining a motor vehicle license that such applicant consent to take breath or blood tests in suspected drunken driving cases. *Approval.*

S-66 Ridolfi—To permit school medical inspectors to accept a report of a pupil's examination by a licensed physician in lieu of an examination by the school medical inspector. *Active Support* (Prepared and introduced by The Medical Society of New Jersey)

S-72 Ridolfi—To amend the Medical Practice Act to permit medical technicians and x-ray technicians operating in a radiological installation maintained by a physician or surgeon, or a radiological installation maintained by a hospital, to perform certain services in connection with technical ancillary services to licensed physicians. *Active Support* (Prepared and introduced by The Medical Society of New Jersey)

SCR-3 Waddington, Ridolfi—To request the Department of Institutions and Agencies to report on the steps necessary to undertake a program of medical assistance for the aged under recent federal amendments to the Social Security Act. *Approval*

A-10 D'Aloia, Martin, Franklin—To regulate the furnishing of public medical services through county welfare boards under the supervision of a new Bureau of Public Medical Services in the Division of Welfare of the Department of Institutions and Agencies. *Action Deferred* . . . pending the introduction of amending and modifying legislation.

A-65 La Morte, Tate, D'Aloia, Laufer—To provide that no person, other than a pharmacist, shall sell any preparation or mixture or compound of drugs containing codeine or any barbiturate to any person under the age of 21, except upon a written prescription of a physician, dentist, or veterinarian. *Disapproval* . . . until recommendation for broadening the prohibition is included.

*A-115 Hauser, Musto, Brown—To allow any legally incorporated humane society to enforce certain of the provisions of the laws relating to cruelty to animals. *Disapproval* . . . because the existing laws which delegate this power to the New Jersey SPCA are adequate.

A-128 Sabello, Marryatt, Higgins—To regulate the practice of physical therapy or physiotherapy. *Disapproval, with active opposition if bill moves* . . . because it is unnecessary and undesirable, since the whole purpose of this legislation—to give proper function under proper control—would be accomplished by simple amendment of the Medical Practice Act.

With one exception—the addition of a sentence—this measure is identical with A-177 of last year, concerning which the Society's position was the same as recorded above.

*A-151 Musto, Hauser, Matthews—To require as a condition precedent to a person's obtaining a motor vehicle license that such applicant consent to take breath or blood tests in suspected drunken driving cases. *Approval*

*A-197 Sweeney, Meloni, Kijewski, Brady, Flynn—To amend the law governing medical services corporations to eliminate requirements that a corporate trust shall be approved by a recognized medical society and that 51 per cent of the licensed physicians in any county must participate before the corporation may transact business therein. *Active Opposition* . . . because it would eliminate the requirements originally insisted upon by the State Commissioner of Banking and Insurance which serve as a guarantee of the quality and adequacy of available medical care for subscribers under the contemplated plans.

A-216 Kraut—To revise generally the law dealing with the operation of motor vehicles after consuming alcoholic beverages. *Disapproval* . . . because it invades the Medical Practice Act and assigns to unqualified lay individuals functions for which they are not licensed and which they should not be allowed.

*A-257 Farrington, Panaro, Sweeney—To amend the act regulating hospital service corporations to allow such corporations to issue a master group contract to employers and other policy holders; gives the Commissioner of Banking and Insurance authority to disapprove practices, rules, and procedures of a hospital service corporation where he feels that they are unjust or inequitable; provides for an annual general supervisory fee to be paid by such corporations. *No Action* . . . unless or until the New Jersey Hospital Association takes a positive stand and requests support of its position by the Medical Society.

*A-259 Farrington, Panaro, Sweeney—Companion bill to A-257; concerns medical service corporations. *Disapproval, with active opposition if bill moves* . . . in support of the contention of Medical-Surgical Plan of New Jersey that the measure would unnecessarily grant the Commissioner of Banking and Insurance "dictatorial powers, and would completely usurp the normal functions and discretion of the Board of Trustees and Plan management."

*A-309 McGowan, Sweeney—To establish the procedure for the Banking and Insurance Commissioner to disapprove rates of medical service corporations and for court review thereof. *Active*

Opposition . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by Medical-Surgical Plan of New Jersey to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

*A-324 Maraziti, Franklin—To permit the appointment of chief medical examiners in 3rd class counties. *Approval*

*A-332-3-6 Panaro, Farrington—Companion bills; to provide hospital, medical, and surgical expense insurance for state employees. *Approval*

A-337 Sabello, Brady—To amend the Workmen's Compensation Act concerning the selection by an employee of a physician or hospital of his own choice; provides for certain specified notice and periodic information to the employer or employer's insurance company with respect to the employee's condition and cost of such care and treatment. *Disapproval, with active opposition if bill moves* . . . because it authorizes the engagement of practitioners not specifically to be "duly licensed physicians," who may not be qualified to treat injured employees.

*A-338-9-40 Werner—Companion bills; amend different sections of the law. Concern presumption in certain illnesses of firemen and policemen. *Disapproval* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

Recommendation: That the listed positions on the foregoing bills be adopted.

The Board has approved these several recommendations.

Relations of Medicine and Psychology

The statement below is published in accordance with instructions from our Board of Trustees. It was developed by the American Psychiatric Association, endorsed by the American Medical Association and recommended for publication here by our Special Committee on Mental Health with approval of our Council on Public Health.

For centuries the Western world has placed on the medical profession responsibility for the diagnosis and treatment of illness. Medical practice acts have been designed to protect the public from unqualified practitioners and to define the special responsibilities assumed by those who practice the healing art, for much harm may be done by unqualified persons, however good their intentions may be. To do justice to the patient requires the capacity to make a diagnosis and to prescribe appropriate treatment. Diagnosis often requires the ability to compare and contrast various diseases and disorders that have similar symptoms but different causes. Diagnosis is a continuing process, for the character of the illness changes with its treatment or with the passage of time, and that treatment which is appropriate may change accordingly.

Recognized medical training today involves, as a minimum, graduation from an approved medical school and internship in a hospital. Most physicians today receive additional medical training, and specialization requires still further training.

Psychiatry is the medical specialty concerned with illness that has chiefly mental symptoms. The psychiatrist is also concerned with mental causes of physical illness, for we have come to recognize that physical symptoms may have mental causes just as mental symptoms may have physical causes. The psychiatrist, with or without consultation with other physicians, must select from the many different methods of treatment at his disposal those methods that he considers appropriate to the particular patient. His treatment may be medicinal or surgical, physical (as electroshock) or psychological. The systematic application of the methods of psychological medicine to the treatment of illness, particularly as these methods involve gaining an understanding of the emotional state of the patient and aiding him to understand himself, is called psychotherapy. This special form of medical treatment may be highly developed, but it remains simply one of the possible methods of treatment to be selected for use according to medical criteria for use when it is indicated. Psychotherapy is a form of medical treatment and does not form the basis for a separate profession.

Other professional groups such as psychologists, teachers, ministers, lawyers, social workers, and vocational counselors, of course, use psychological understanding in carrying out their professional functions. Members of these professional groups are not thereby practicing medicine. The application of psychological methods to the treatment of illness is a medical function. Any physician may utilize the skills of others in his professional work, but he remains responsible, legally and mor-

ally, for the diagnosis and for the treatment of his patient.

The medical profession fully endorses the appropriate utilization of the skills of psychologists, social workers, and other professional personnel in contributing roles in settings directly supervised by physicians. It further recognizes that these professions are entirely independent and autonomous when medical questions are not involved; but when members of these professions contribute to the diagnosis and treatment of illness, their professional contributions must be coordinated under medical responsibility.

Memorial to Dr. Rogers

A bronze tablet, given by the employees, has been installed at the Rogers Building at Donnelly Memorial Hospitals, Trenton. Its inscription, bordered by ivy leaves, reads: "Dedicated to the Memory of Lawrence H. Rogers, M.D., for faithful service at Donnelly Memorial Hospitals, 1914-1959."

The late Dr. Rogers, who was appointed City Physician of Trenton in 1914, became Medical Director of the Municipal (now Donnelly Memorial) Hospitals in 1925—a position he held until his death. With the exception of almost two years' military service during World War I, he served the City of Trenton for 45 years. The building for aged and chronically-ill patients at Donnelly Hospitals was named in his honor in 1954.

In his recent tributes to Dr. Rogers, Mayor Arthur J. Holland said that "his career was the history largely of Trenton's care of its aged and ill." Speaking for his professional associates, Dr. Paul Klempner cited Dr. Rogers' sympathy for the sick, helpful attitude and medical skill.

Annual Report of the Gloucester County Medical Society*

Thomas F. Flynn, Jr., M.D., President, Woodbury

At the May 1960 meeting an engraved gavel was presented to Dorothy M. Rogers, M.D., the retiring President.

Interesting speakers and programs were scheduled for the year. Dr. Chester I. Ulmer, of our Society, was the speaker at the annual social session in October.

Questions relative to the need for a county hospital were referred to a committee for study in cooperation with the Gloucester County Board of Freeholders. The decision of both groups was that the present hospital facilities are adequate.

Dr. A. Guy Campo received an award from the American Academy of General Practice for his excellent work in legislation, and was installed as President of the New Jersey Chapter.

Seven members volunteered to assist in the Boy Scout program of physical examinations for camp enrollment.

The Dental and Pharmacy Societies were guests of the Society at two meetings.

Six applications have been received and two applicants have been elected to membership. One resignation was accepted and one member died. Total membership of the Society as of March 18, 1961, was 70.

One of our proudest highlights of 1961 was the consummation of our much-discussed plan to incorporate the Gloucester County Medical Society. This became official on February 1, 1961.

* Received too late for our April issue.

Obituaries • • •

DR. RALPH APPLETON

While delivering a historical lecture in a school auditorium on March 14, Dr. Ralph Appleton suddenly collapsed and died of a coronary attack. Born in Bristol, Pennsylvania in 1900, Dr. Appleton earned his M.D. at Hahnemann in 1927. After interning in Providence, Rhode Island, he returned briefly to his native state for general practice. In 1937 he moved to Point Pleasant, New Jersey and did general practice in that area for more than a quarter of a century. He was affiliated with the Point Pleasant Hospital, and served there in all capacities from clinical assistant to chief of internal medicine. He also had a period of duty as chief of staff of the hospital. He was active in the American Academy of General Practice. Dr. Appleton was a well known authority on the Civil War and since the centennial of that conflict began last year, he was in constant demand as a speaker. He was program director of the Ocean County Round Table, a study group devoted to the Civil War.

DR. ALBERT J. BERES

A heart attack on March 28 took the life of Dr. Albert J. Beres of Woodridge. Born in Hungary in 1900, Dr. Beres earned his M.D. in 1927 at the medical school of New York University. After interning at Paterson General Hospital, he went to Holy Name Hospital for a general practice residency, and then elected to remain in Bergen County. He was active in the affairs of the Academy of Medicine, and in the work of the Bergen County Medical Society. Dr. Beres was a general practitioner and a well-known family doctor in the Bergen County area.

DR. ALDRICH C. CROWE*

Death came on Easter Sunday to our 1950 State Society President, when Dr. Aldrich C. Crowe died on that day. Born in Alabama in 1898, Dr. Crowe came north to go to the Jefferson Medical College. There he received his M.D. in 1921. After interning at the Philadelphia General Hospital, he returned briefly to his native state for a pediatric residency at the Birmingham Baptist Hospital. In 1925 he decided to make New Jersey his home, and he served the children and parents of south Jersey ever since that year. He rose rapidly through the official ranks of the Cape May County Medical Society, becoming its president in 1939. He served our State Society as a Trustee continuously since 1936, becoming secretary of that Board in 1938 and its chairman in 1946. In 1947 he entered the primary rank of the State Society's presidential ladder, being elected second vice-president that year. For the past seven years he has been a New Jersey delegate to the American Medical Association.

*For editorial comment on Dr. Crowe's death, see page 195 of this JOURNAL.

DR. DAVID EISENBERG

Dr. David Eisenberg, one of northern New Jersey's best known orthopedists, died on April 4. Born in Newark in 1902, Dr. Eisenberg received his M.D. at the University of Pennsylvania in 1927. After interning at the old Newark City Hospital, he entered private practice. He became increasingly interested in orthopedic surgery and industrial medicine, and became a diplomate of the American Board of Orthopedic Surgery. He was senior industrial physician for the New Jersey Division of the Lehigh Valley Railroad, for the Celanese Corporation and for the Battery Unit of Thomas A. Edison Industries. Dr. Eisenberg was affiliated with many hospitals in northern New Jersey and was chief of orthopedics at Martland, at Beth Israel and at the Hospital and Home for Crippled Children. A member of the Board of Congregation Oheb Shalom, he was active in many religious, civic and fraternal affairs.

DR. SEYMOUR S. ESTRIN

On April 4, a heart attack took the life of Dr. Seymour S. Estrin at the Fitkin Hospital in Neptune. Born in Newark in 1913, Dr. Estrin received his M.D. at the University of Michigan in 1936. After interning at the General Hospital in New Rochelle, he spent some time in Brazil doing work in tropical medicine. He then moved to Warren County, New Jersey, where he practiced for several years. In 1942 he entered the Army of the United States, serving throughout the war. He was in Norway under fire, and for services rendered the Norwegian people, he received a citation from the King of Norway. On returning from military service, he made his home in Monmouth County, with offices in Bradley Beach and his residence in Deal. He was active in veterans' and church affairs and belonged to the Monmouth County Medical Society.

DR. LEWIS C. FRITTS†

A heart attack took the life of Dr. Lewis C. Fritts on April 6. Born in 1903, Dr. Fritts was graduated in 1930 from the Jefferson Medical College. After interning at the Philadelphia General Hospital he did graduate work in physical medicine and then moved to New Jersey where he set up an office in Somerville for general practice. He served the Somerville Hospital in all grades and developed the rehabilitation service there. Dr. Fritts served several years as chief of staff at that hospital. Similarly he was active in all phases of county medical work in Somerset, becoming president of the Somerset County Medical Society in 1942. He became interested in state medical affairs shortly thereafter, and served with distinction on a number of committees and on our Board of Trustees. In 1956 he was selected as President of The Medical Society of New Jersey.

DR. WILLIAM LEVISON

At the untimely age of 51, Dr. William Levison died of a heart attack on April 4. Born in Germany in 1910, Dr. Levison earned his M.D. at Heidelberg in 1932. The following year he emigrated to the United States and won a pathology fellowship at New York's Mt. Sinai Hospital. In 1938 he moved to Newark, and entered the private practice of medicine, specializing in metabolic disorders. During World War II, he was commanding officer of an Army Laboratory in Hawaii and Okinawa. He then became a consulting pathologist to the Veterans Administration. He was a diplomate of the American Board of Internal Medicine, and a past-president of the New Jersey Diabetes Association. Dr. Levison was a Fellow of the American College of Physicians.

DR. JOHN J. PAGLIUGHI

Dr. John J. Pagliughi of Union City died on February 15 at the age of 65.

Born in New York, Dr. Pagliughi received his M.D. degree from New York University in 1920. He had been director of otorhinolaryngology at the Pollak Hospital in Jersey City and had been associated with that institution since it opened 36 years ago. He was consulting bronchoscopist at Christ Hospital and Professor of Clinical Otorhinolaryngology and Bronchoscopy at Seton Hall College of Medicine. Dr. Pagliughi was a Fellow of the American Academy of Ophthalmology and Otolaryngology.

DR. JOSEPH N. ROY

Dr. Joseph N. Roy, chief of gynecology at the Paterson General Hospital, died there on March 16 after a short episode of coronary decompensation. Born in Newark in 1900, he was graduated in 1922 from Bellevue, and won one of the coveted Bellevue Hospital internships the following year. He returned to New Jersey, setting up offices in Paterson, whose people he was to service for almost 40 years. He soon became affiliated with the General Hospital, and was appointed to the gynecologic staff in 1931. He served in all ranks, becoming, in 1947, chief of that department. He was active in the Paterson Rotary Club and in the affairs of the Passaic County Medical Society. In 1952, Dr. Roy was elected chief of staff at Paterson General Hospital.

DR. LAWRENCE L. URBAN

One of the leaders in Hudson County Polish-American affairs, Dr. Lawrence L. Urban died at his home in Bayonne on March 12 at the age of 63. Dr. Urban came to the United States in 1914 at the age of 16. In 1922 he received his M.D. at Temple and interned at St. Francis Hospital in Trenton. For a decade he did general practice in Elizabeth and in 1934 he moved to Bayonne. A general practitioner, he was a medical examiner for the Bayonne Board of Education and physician to the Hudson County Welfare Board. He was a national vice-president of the Polish-American Medical Association and active in the affairs of the Hudson County Medical Society.

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†For editorial comment on Dr. Fritts, see page 196, this JOURNAL.

Announcements • • •

Blood Bank Seminar

A Blood Bank Seminar sponsored by The Medical Society of New Jersey, in cooperation with the State Department of Health and Rutgers University, will be held on May 20, 1961 in Voorhees Hall, Rutgers University, New Brunswick, at 10 a.m. sharp. You are cordially invited.

Lester J. Unger, M.D., Blood Bank Director of New York University Medical Center, will talk on "dangers associated with transfusions." Then Aaron Kellner, M.D., Director of Laboratories at the New York Hospital, will speak on "Recurrent Problems in the Operation of Blood Banks."

Psychiatric Seminar

On Thursday evening, June 22, the Eastern Psychiatric Research Association will hold a colloquium at New York University Medical School, 30th Street and First Avenue, New York City. The meeting, which will start at 8:30 p.m., will cover three topics: (1) psychiatric pharmacology; (2) ambulatory electronic therapies; and (3) organizations of ex-patients of mental hospitals. You are invited to attend.

Training in Environmental Health

Scientists interested in environmental and industrial health are advised of the availability of special courses in this field at New York University. United States Public Health Service training grants are available. Fields of special interest include air pollution, industrial toxicology, aerosol physics, radiation biology and related areas. Curricula may be fashioned for engineers, pharmacologists, statisticians, physicists, chemists and physicians. Inquiries should be directed to Institute of Industrial Medicine, 550 First Avenue, New York 16, N. Y.

Chest Physicians

The Annual Meeting of the American College of Chest Physicians will be held at the Commodore Hotel, New York City, Thursday, June 22 through Monday, June 26. Scientific sessions will open Saturday, June 24 and will continue through Monday, June 26. On Monday there will be a joint session with the Section on Diseases of the Chest of the American Medical Association.

The popular Fireside Conferences, sponsored by both the AMA and the College, will be held at the Commodore Hotel, Monday evening, June 26.

Dr. A. A. Carabelli, Trenton and Dr. Irving J. Selikoff, Paterson, will participate in the programs. More details may be obtained from the American College of Chest Physicians at 112 East Chestnut St., Chicago 11.

X-Ray Therapy Lecture

On May 25, 1961 at 5:30 p.m., there will be presented the Tenth Annual Ira Kaplan Lecture. The essayist this year is Dr. Walter T. Murphy the distinguished director of radiology at Roswell Park Institute in Buffalo. His topic: complications of head and neck irradiation. The meeting will be held in Alumni Hall, N. Y. University School of Medicine at 31st Street and First Avenue, New York.

Chest Disease Course at Saranac

A unique opportunity for graduate-level training and a 3-week stay in upper New York State is offered by the Trudeau School. This organization will hold its 46th session at Saranac Lake during the period June 5, to June 23 and will give intensive training in all aspects of chest diseases. Tuition is $100 for the three-week session. Inquiries should be directed to Trudeau School at Box 670, Saranac Lake, New York.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held at the Children's Seashore House on February 10. The president, Dr. Harvey Vandegrift introduced the speaker for the evening, Mr. Howard I. Jacobson.

Mr. Jacobson, a local accountant and past president of the Cancer Society of Atlantic County, gave an enlightening discussion on "Your Tax Problem." In reviewing Income Tax Form 1040, he explained the difference between a cash and an accrued basis. He gave a thorough review of expenses, depreciation, educational expenses, bad debts, exemptions and deductions. He explained capital gains, corporations, and partnerships. At the close of his formal talk, Mr. Jacobson answered questions from the floor. This meeting was a most fruitful one, and we are deeply indebted to Mr. Jacobson.

At the subsequent business meeting, it was announced that Dr. Hilton Read was honored by the Brotherhood Council of the National Conference of Christians and Jews, as the outstanding fellow-citizen of Atlantic County for 1961.

Dr. Albert Marchetti was accepted into the Society as an Associate member. Dr. Solon Worth Clark, a physician since 1911, was nominated for the Golden Merit Award.

The meeting was then adjourned.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held March 14 at Bergen Pines Hospital, Paramus, was called to order by George O. Rowohlt, M.D., President.

Membership certificates were presented to the following new Active members: Drs. Louis Reuling, Arnold M. Sobel, Max K. Griffel, Jaroslaw Rozankowski, and Thomas F. Lenihan.

The following Associate members were introduced: Drs. Arnaldo N. Apolito, Barnett L. Elkin, and Mary Elkin.

The following were elected to membership: *To Active*—Harry Kosovsky, and John R. Doyle; *To Associate*—John Apovian; *To Courtesy*—Harry H. Hershey, Howard E. Medinets, and Mark M. Singer.

The Secretary read the proposed amendment to the Bylaws of the Society which would add the office of President-elect and moved its adoption. Motion passed.

Pending Legislation: The Executive Secretary outlined three bills before the State Legislature and asked members present to inform their legislators of their position on these bills. The position of this Society corresponds with that of The Medical Society of New Jersey: approval of S-66 and S-72 and opposition to A-197.

By-laws: The Union County Medical Society proposes to amend the Bylaws of the State Society to provide for the election of at least one State Society Trustee from each component society. There is a provision that the larger societies would elect one trustee for every five hundred members. After prolonged debate, the matter was tabled until the Annual Meeting in May.

The Chair turned the meeting over to Dr. R. P. Keating, Program Committee Chairman, who informed the members that last fall Dr. Luther Terry of the National Heart Institute had accepted his invitation to address this meeting. Shortly after the January 20 inauguration, the President had named Dr. Terry Surgeon of the United States Public Health Service. Under these circumstances, it was not possible for Dr. Terry to be present. He had designated Dr. Samuel M. Fox, Assistant Director of the National Heart Institute to speak for him. Dr. Fox described the organization and expansion of the National Institutes of Health. He emphasized that civilian consultants were important and weighty in decisions made by federal administrators of the Institutes. He described how to submit a patient for study. Pamphlets detailing the organization and use of the Institutes were left with the Society and may be obtained from our headquarters. At the close of his presentation, a lively question and answer period followed.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

The *Burlington County Medical Society* convened in regular session on March 9 at the Millside Farms Dairy Bar, Route 130, Riverside. President Boudwin called the meeting to order at 8:15 p.m. Attendance, 43 members and 12 guests.

Our program, arranged by Dr. Paul R. Sparks, was a symposium on "Allergy" by Dr. Joseph Ziegler and Dr. Harry L. Rogers.

The following guests were welcomed: Drs. Kuler, Phalon, O'Brien, Bell, Byrne, and Wolfson, all from the McGuire Air Force Base; and Drs. Burke, Greenspan, Rosenberg, Greenfield, Smith and Tatarian, all being applicants for membership in our Society.

The Secretary reported several resolutions from other county societies, asking for endorsement of their resolutions at the 1961 Annual Meeting of The Medical Society of New Jersey.

Dr. Barton, Chairman of the Board of Censors, presented the following applications for membership:

For Regular membership: Val. S. Greenfield, Riverside, transferring from Philadelphia County Medical Society; Thomas R. Hedges, Jr., Moorestown, transferring from Associate membership; Jack N. Rosenberg, Levittown, N. J., transferring from Philadelphia County Medical Society; Irwin S. Smith, Levittown, N. J., transferring from Philadelphia County Medical Society; Gabriel Tatarian, Levittown, N. J., transferring from Cumberland County Medical Society; Alan F. Wirtshafter, Levittown, N. J., transferring from Associate membership.

For Associate membership: Martius J. N. Ashhurst, Moorestown; John N. Burke, Medford Lakes; Richard J. Eberly, Moorestown; June E. Greenspan, Riverton.

A letter was read announcing a vacancy for a physician at the State Colony at Four Mile, either full or part time. This offers opportunity for a wide range of medical experience. Any physician desiring to apply should call Dr. Ingham or Philip S. Thomas at Four Mile.

The president asked for a panel of members available to speak before different organizations. The panel would work under the public relations committee. Volunteers would be appreciated.

There being no further business, the meeting adjourned at 10:20 p.m. to talk informally about issues brought up at the meeting and to "feed the inner man" at the buffet table.

EDWARD D. WILDMAN, M.D.

Reporter

Cumberland

The April meeting of the *Cumberland County Medical Society* was held at the White Sparrow Inn at the Circle, Vineland, at 9:30 p.m., April 11, with Alfred O. Davies, M.D., of Millville, presiding.

At this meeting the annual election of officers was held and those to assume their duties in June are:

President—Harry A. Reinhart, Vineland; Vice-President—Ralph S. Phillips, Bridgeton; Secretary—Frank J. T. Aitken, Bridgeton; Treasurer—Earl C. Lyon, Bridgeton; Reporter—Leonard G. Scott, Bridgeton.

Members of the Executive Committee (1 year)—Robert A. Levenson, Vineland; Sherman Garrison, Jr., Bridgeton; Sol Rosen, Millville. Delegates to The Medical Society of New Jersey—Mary Bacon, Bridgeton; Sidney L. Siegel, Millville. Alternate Delegates—Milton Fineman, Vineland; Pasquale A. Ruggieri, Vineland. Member of Nominating Committee of The Medical Society of New Jersey—Nicholas E. Marchione, Vineland; Alternate—Sherman Garrison, Jr. Judicial Committee—William S. Fithian, III, Bridgeton. Members of the Cumberland County Nominating Committee (1 year)—George Parnell Glenn, Jr., Vineland; George H. Huston, Bridgeton; Peter E. Penico, Millville.

Dr. Mary Bacon gave an interim report of the Maternal and Infant Welfare Committee's research studies that are being conducted in this county.

Congratulations were extended to President Alfred Davies, who has been certified as a Diplomate of the American Board of Surgery.

Congratulations were also extended to Dr. Elmer N. Mattioli. Dr. Mattioli was recently appointed Chief of Staff at Newcomb Hospital and consultant in thoracic surgery at Ancora State Hospital.

The Society welcomed Drs. Renaud Blanchet and Vladimir Kohut of Vineland to Associate membership.

Mr. William Allen Steadman, guest speaker, gave a most interesting discourse on a topic he titled "Dollar Delirium."

LEONARD G. SCOTT, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding, the regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on Tuesday evening, March 7. Speaker of the evening was Dr. Benedict J. Duffy, Chairman of the Department of Preventive Medicine at Seton Hall College of Medicine. Dr. Duffy's topic was "Medical Aspects of Air Pollution."

A resolution was passed that the Hudson County Medical Society go on record as being in favor of the Kerr Mills Law. It was directed that letters be sent to Senators and Congressmen advising them of this action.

Following the business meeting, a collation was served.

LOUIS KOSMINSKY, M.D.

Reporter

Middlesex

A joint meeting of the *Middlesex County Medical Society* and Middlesex County Pharmaceutical Association, under the chairmanship of Dr. Stanley Gadek, president of the former organization, was held at Oak Hills Manor, Metuchen, on March 15. On recommendation of the Judicial Medical Ethics Committee, the following applications for membership were presented to the Committee on Credentials: Dr. Palma E. Formica, Old Bridge, to Regular membership from two years' Associate membership; to Regular membership from the Hudson County Medical Society, Dr. Stanley Bresticker, New Brunswick; and two years' Associate membership to Dr. Lawrence Julius Arnone, New Brunswick.

Minutes of the February meeting were approved as read.

Dr. Robert Heath, Director of Public Relations at Merck Sharp & Dohme, gave an interesting and informative talk on "The Dynamics of the Pharmaceutical Industry." He emphasized the financial aspects of the industry and what it has meant in terms of better drugs, lower prices and a stable growing industry.

An excellent buffet supper and lively informal conversation were then enjoyed by all.

THOMAS I. STEINBERG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on February 21 at the Medical Society Building. The meeting was called to order by Dr. F. Albert Graeter, president.

Dr. Ivan D. Barchenko of Passaic was elected to Active membership.

Nominees for election as Delegates and Alternates to the Annual Meeting of The Medical Society of New Jersey in May were presented. The presented panel was unanimously elected for a three-year term (1961-1962-1963).

Dr. Graeter read a copy of a letter which had been sent to Mayor Graves of Paterson by Mr. Conrad Corsini, President of the Paterson Chamber of Commerce. This letter requested that the Mayor give favorable consideration to replacing Dr. Lee with a physician in order that Paterson may continue to maintain the high standards it has always had in the public health field.

The meeting was then turned over to Dr. Edward Wolfson, Program Chairman, who introduced Daniel Bergsma, M.D., M.P.H., Associate Medical Director of The National Foundation and Arden W. Moyer, head of Virus Biologic Research for Lederle Laboratories. The subject for the evening was the development of poliomyelitis vaccines. A discussion and debate followed on the relative merits and public health aspects of both the Salk vaccine and the Oral Live Virus vaccine. A question and answer period followed.

At the conclusion of the scientific program, a collation was served.

IRVING CHRISMAN, M.D.

Reporter

1961-62 MEMBERSHIP DIRECTORY

Is Your Listing Correct?

The 5th Edition of the biennial Membership Directory is scheduled for publication and distribution in the summer of 1961.

Make sure your listing is accurate and complete by checking your current listing and submitting any changes and/or additions PROMPTLY — in printed form—to the:

MEMBERSHIP DIRECTORY DEPARTMENT

THE MEDICAL SOCIETY OF NEW JERSEY

P. O. Box 904, Trenton 5, N. J.

Book Reviews

Progress in the Treatment of Fractures and Dislocations 1950-1960. By Thomas B. Quigley, M.D. and Henry Banks, M.D. Philadelphia 1960. Saunders. ($2.50)

The material contained in this small volume first appeared in the New England Journal of Medicine as one of a series of progress reports in various fields of medicine. It presents the authors' views regarding the application of studies published during the last decade for the conduct of an active service in a teaching hospital. Both authors are eminently qualified by training and experience to discuss this most important field and to present the pitfalls with the most common errors responsible for bad results. Their conclusions are pointed and logically presented.

The comment on Polyurethane foam is interesting—"Within two years of its first reported experimental trial in 1958, this substance has been well tested. Enough data have accumulated from both laboratory and human experience to justify certain conclusions. It is probably nontoxic and non-carcinogenic. Its use presents considerable technical problems. Complications, even in very competent hands, are frequent." They feel that its use at this time, however, should be confined to pathological fractures and cases of non-union that have not healed despite several competent bone grafts and for which amputation is the only alternative.

Their observation that in children "open reduction can almost categorically be condemned with few exceptions as meddlesome and unnecessary," is, to me, well taken. They point out that the initial enthusiasm for open reduction of the clavicle has waned and in fractures of this bone "some degree of cosmetic asymmetry may occur, but real disability is almost unknown." This is the first time I have seen this statement in print but I thoroughly agree.

Their observation on "fractures through the junction of the distal and middle third of the radius in the presence of an intact ulna is, as Hughston pointed out, practically impossible to reduce and hold in acceptable position without operation," is very often disregarded and the viewpoint on the use of hardware and skeletal fixation in primary open reduction is not received very kindly.

The text is worthy of high praise and is particularly valuable for the average fracture surgeon.

DANIEL F. FEATHERSTON, M.D.

Bedside Diagnosis. Charles Seward, M.D. Baltimore 1960. Williams and Wilkins. Pp. 479. Ed. 5. ($6.00)

Since 1949, Seward's has been a compact diagnostic handbook for British practitioners. Each major presenting symptom is discussed with a list of the investigations needed to perfect a diagnosis. The approach is more sophisticated than the traditional one of trying to match the patient's complaints with a diagnostic profile that seems most closely to resemble it. Included is a unique chapter on radioisotopes in diagnosis. An especially valuable section is one on drugs as a cause of symptoms. The book closes with a useful chapter on normal values in the cardiovascular, renal, gastrointestinal, endocrine and cerebrospinal systems.

VICTOR HUBERMAN, M.D.

Human Pituitary Hormones. Edited by G. E. W. Wolstenholme and Cecilia M. O'Connor. Boston, 1960. Little, Brown & Company. Pp. 336.

This colloquium on human pituitary hormones was sponsored by the Ciba Foundation in honor of Professor B. A. Houssay of Buenos Aires, a pioneer investigator of the role of the anterior pituitary gland in the carbohydrate metabolism. Dr. Houssay won a Nobel prize in science.

This seminar deals with the chemical and biologic analysis and comparative studies between human pituitary hormones (H.P.H.) and pituitary extracts from other animals. Immunologic studies were also carried out. Extracts were administered by intramuscular injection daily for 10 to 16 days. During this period, metabolic and physiologic studies were carried out in animals, normal human subjects, acromegalics, dwarfs and amenorrheic and menopausal women.

Although the method of preparation and administration varied somewhat in different centers of endocrine research, the general consensus was that the most constant metabolic indication of the effectiveness of the H.P.H. was nitrogen retention, indicating its anabolic effect.

Potassium retention was not as constant as nitrogen retention, but it occurred in the majority of cases. There was also retention of sodium, chlorides, and phosphorus and an increase in calcium and creatinin excretion.

Extracts of monkey pituitary glands injected into human subjects produced similar metabolic changes. No such effect could be produced by pituitary extracts obtained from other animals, including the whale pituitary extract. This species

specificity applies particularly to the growth and follicle stimulating factors of the H.P.H.

Partly purified fractions of the human anterior pituitary hormones, such as growth, follicle stimulating hormone, luteinizing hormone, interstitial cell stimulating hormones, thyrotropic and adrenotropic hormones were isolated in the animals in the human and were found to be potent.

Although the metabolic and physiologic effects varied somewhat when different methods of preparation were used, these extracts were found to be potent in the human subjects.

The human pituitaries were obtained at autopsies from various large hospitals for scientific studies in specialized scientific centers. These products are not available for general use, unless cultures or synthetic preparations will be achieved in the near future.

This book is an inspiring collection of authoritative and thoughtful papers.

RITA S. FINKLER, M.D.

Yoga: A Scientific Evaluation. By Kovoor T. Behanan, Ph.D. New York 1960. Dover Publications. Pp. 165. With seventeen photographs. ($1.65)

Dr. Behanan seeks to offer the Western reader a non-mystical explanation of Yoga, both as a form of psychotherapy (perhaps through auto-suggestion) and as a form of physiologic self-control. This book was first published in 1937 and is now offered in an inexpensive paper-bound edition. Dr. Behanan calls for more experimental work. In spite of the author's sincere effort to demysticize yoga, much of it still sounds strange to Western ears.

HERBERT BOEHM, M.D.

Lymphatics and Lymph Circulation. By Istvan Ruszнyak, Mihaly Foldi, and Gyorgy Szabo. New York 1960. Pergamon Press Inc.

This volume consists of three books. The first one is concerned with the history and architecture of the lymphatic system. The second deals with physiology and pathology of the lymphatic system; and the third pertains to the special physiology and pathology of the lymphatic system.

The first book covers the discovery of the lymphatic circulation by Asellius in 1627. The second part of the volume dealing with the physiology and pathology of the lymphatic system needs to be rewritten. It consists of a lengthy presentation of various theories, both true and false, pertaining to the anatomy and physiology of the lymphatic system. At times the author becomes verbose in the presentation of theory. This section of the book would have been more readable had the author condensed his facts rather than attempting to confuse the reader by a plethora of ideas. Those who regard brilliance in writing as the ability to present an indefinite number of controversial facts upon many subjects will disagree with this opinion.

The third portion of the volume dealing with the special physiology and pathology of the system was more readable. It reviews the second part of the volume while presenting facts applicable to individual organs. A profuse bibliography and index of names and subjects complete the volume.

In general there were many typographic errors noted, the most outstanding of which were the designation of the great physiologist Starling as "Startling's Theory" and the use of the term coacervation when the the word obviously meant was coagulation. The frequent use in the text in parentheses of responsible authors' names became monotonous to the reviewer. To those interested in the lymphatic system, this volume is a source of considerable authoritative, historical, and physiologic information. The pathology presented was buried in profuse descriptive detail.

THOMAS K. RATHMELL, M.D.

May's Manual of Diseases of the Eye. Edited by Charles Perera, M.D. Baltimore 1959. Williams and Wilkins. Ed. 22. Pp. 424, illus. ($6.00)

In the first edition of May's *Diseases of The Eye*, the author "endeavored to present a concise, practical and systematic manual of the diseases of the eye, intended for the student and the general practitioner of medicine." In preparing this 22nd edition, the editor has "resisted the temptation to increase the size and scope of the volume. The author's desire to make available an authoritative textbook of ophthalmology suitable for the medical student and practicing physician has been maintained."

Dr. Charles A. Perera has done exactly that. The usual diseases of the eye and its adnexa, including inflammatory processes and tumors, are succintly covered. Adequate descriptions of tests of vision, both direct and indirect, and for color and for depth perception, are described. The more recent treatments for glaucoma are indicated, although the details of the refinements of tonometry are not developed. Of especial interest to the general practitioner is the chapter dealing with eye injuries and the estimation of the loss of visual efficiency, which is important in compensation work.

This is a valuable book for the medical student and for the general practitioner. It also has a place in the library of the busy ophthalmologist.

WILLIAM H. HAHN, M.D.

Infectious Diseases of Children. Saul Krugman, M.D. and Robert Ward, M.D. St. Louis, 1960. Mosby. Ed. 2. Pp. 398. ($13.00)

The warm reception given the first printing of Krugman-Ward has justified this new edition. Rapid accumulation of our knowledge of viruses alone would make revision necessary. The text includes some new and interesting material on rabies prevention. In the chapter on acute respiratory infections there is a conscientious effort to cut through the therapeutic jungle and give solid suggestions about treatment. Syphilis, tuberculous and fungous infestations are not discussed, except rather tangentially but there is up-to-date data on adenoviruses, pneumonia, hepatitis, chickenpox and diphtheria immunization. Also included is usable material on Salk and Sabin poliomyelitis vaccines. The book is further enriched by a valuable chapter on the public health problems of controlling communicable disease. All in all, this is a practical text for the pediatrician, internist or general practitioner.

RALPH N. SHAPIRO, M.D.

The Management of Fractures and Soft Tissue Injuries. By the Committee on Trauma, American College of Surgeons. Based on an Outline of the Treatment of Fractures, 7th Ed., and Early Care of Acute Soft Tissue Injuries, 2nd Ed. Philadelphia, 1960. Saunders. Pp. 372, illus. ($5.00)

This small volume is a combination of the time-honored *Fracture Manual of the American College of Surgeons* and the second edition of the *Manual on Soft Tissue Injuries*. The concept of a single compendium on trauma is a good one, but this volume falls somewhat short of the goal. One would wish that the two sub-committees had combined their information logically into one volume rather than simply putting the two manuals in tandem. There is considerable repetition of information in each half of the book with a good deal being said in the soft tissue section about fractures. In some instances this information is in actual contradiction to that found in the fracture half of the book. Furthermore, it would seem reasonable that the very good introductory chapters in Part II (concerning the assessment of the injured, infection, anesthesia and shock) might well serve to introduce the entire volume. These principles apply as much to the care of skeletal as to the care of soft tissue injuries. It would then seem logical to follow with the discussion of the individual areas in sequence from the head down in respect to both soft tissue and skeletal injuries. This would have made for a cohesive and orderly presentation of material.

The book encompasses a tremendous amount of information in a small volume with concise and, of necessity, limited instructions in the care of specific problems in trauma. There is little to disagree with in the facts presented. The fracture manual has served for almost thirty years as a ready pocket reference for House Staff and Attending alike in the care of skeletal injuries. Individually (and the two volumes are available separately) these two volumes will continue to serve a useful purpose for all surgeons dealing with trauma, and for the teaching of House Staff in the care of the injured. The two volumes individually should certainly be in the hands of anyone dealing with trauma. Combined into one volume they are, I believe, less useful.

EUGENE A. WHITE, M.D.

What Price Medical Care? Sir Earle Page. Philadelphia 1960. Lippincott. Pp. 159. ($3.50)

Australia has a system of health and hospital insurance described as "Government cooperation without Government control." There are dozens of "friendly societies" in that Commonwealth—corresponding more or less to our Blue Cross and Blue Shield plans. The Government pays a modest schedule of fees to any doctor or hospital for treating anything in anybody. The fees are too low to provide full coverage. But if the patient also carries private (organization or society) insurance, the combined indemnities generally cover 100 per cent of the bill. What it amounts to is Government encouragement of, and back-stopping of, private insurance. People on old-age or disability pensions get all drugs free; others pay a modest cost (as, *e.g.* 60 cents in our money for any quantity of an expensive steroid, tranquilizer or antibiotic).

It is hard to figure out whether this would work in our country. Physicians' incomes are lower in Australia than in the U.S.A.—but so are physicians' expenses. In this book, Sir Earle Page, a well known Australian surgeon and father of this scheme, tells us about it. Apart from numerous, and unnecessary, rambles into anecdotage, the text tells the story well, though rather repetitiously in spots. It is a good narrative but the absence of an index makes it useless for serious research. It is gratifying to read that all the Government's paper work in connection with this program is carried on in Canberra by a staff of 18 employees. *Australia felix* indeed!

HENRY A. DAVIDSON, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MAY, 1961 • VOL. XXXIV, No. 5

SURGERY IN THE MANAGEMENT OF PULMONARY TUBERCULOSIS

Resection is the surgical treatment of choice today. In a series of five hundred patients at Fitzsimons Army Hospital only five patients died following resections. Even with good drugs, surgery has a significant role in the management of tuberculosis.

The presently available highly effective antimicrobial agents, used singly or in combinations, are seemingly sufficiently specific to raise the question whether surgery in the treatment of pulmonary tuberculosis will always be necessary in countries with economic levels and medical advancements comparable to the United States. However, there are still many untoward factors and circumstances that prevent successful management without the aid of surgical measures.

Some of these factors and situations may be listed as follows: delay by the patient in seeking medical aid; diagnostic errors and incomplete evaluation by physicians and surgeons (such circumstances contribute to delay in proper treatment, thus contributing to the development of irreversible pulmonary lesions); economic factors; uncooperative and recalcitrant patients; drug hypersensitivity unfavorably influencing medical management; inadequate dosage or duration of drug regimens; initial infection by or development of drug resistant mycobacteria; associated diseases such as silicosis and malignancy; improper or meddlesome use of potent hormonal agents such as corticotropins and corticosteroids; infection by unusual acid-fast strains or mutants (some not presently understood or fully evaluated, such as atypical chromogenic mycobacteria); the less commonly occurring relapsing lesions, and, of considerable consequence, the ever-present influence of mulcting or quackery.

JOHN M. SALYER, Colonel, M.C., *Rocky Mountain Medical Journal*, August, 1960.

SURGERY STILL IMPORTANT

Therefore, regardless of whether the ideal antituberculosis drug is developed in the near future, it seems logical to predict that surgical endeavors will play an important and significant role in a considerable percentage of therapeutic efforts in the management of pulmonary tuberculosis for at least two or three generations.

Since 1949 resection has steadily increased in popularity as a surgical procedure and now most thoracic surgeons and medical chest specialists are inclined to consider extirpative measures as the best surgical means of treating pulmonary tuberculosis. Primary extraperiosteal thoracoplasty, extraperiosteal plombage, and Monaldi drainage are always kept in mind but seldom employed. By and large, phrenemphraxis, pneumothorax, and primary pneumoperitoneum are procedures to be thought of and referred to only in terms of historical deference.

During the past five years the Thoracic Surgery Service at Fitzsimons Army Hospital has performed from 102 to 235 pulmonary and pleural resections each year in the treatment and diagnosis of tuberculosis.

The properly performed segmental resection for localized disease continues to be the

procedure of choice and has been at this hospital since 1952. Wedge resections, by and large, should seldom be performed for proved tuberculous lesions; however, wedge removal may be utilized occasionally for small, well-localized peripheral lesions incidental to the primary lobe or segmental resection.

INDICATIONS FOR SURGERY

When surgery is indicated after prolonged chemotherapy (four to eight months), our criteria for resection for the past four years has been essentially as follows: (1) cavitary lesions, unquestionably persistent; (2) cavitary residuals, open or closed, often referred to as "tuberculous abscess;" (3) large caseonodose residuals, 2 cm. or more in greatest diameter; (4) tuberculous bronchiectasis, severe and localized.

Resection is also called for for the following less commonly encountered lesions: (1) so-called "destroyed" lobe or lung; preoperative pulmonary function studies must be done and properly evaluated; (2) chronic relapsing localizing disease; (3) persistently positive sputum; (4) progression of disease under apparently adequate chemotherapy; (5) atelectasis and/or tuberculous pneumonia; (6) bronchopleural fistulae, secondary to previous excisional surgery; (7) infarction of adjoining segment or subsegment after pulmonary resection; (8) the so-called salvage case, i.e., patients with associated limited or poor pulmonary function, often persistently positive with resistant bacilli.

After relatively short periods of chemotherapy the indications for surgery are (1) solitary or multiple lesions, where diagnosis cannot be established; (2) pleural effusion; (3) relatively localized disease which is the suspected site of repeated gross bleeding; (4) mixed empyema, resulting after spontaneous pneumothorax associated with destroyed lung.

Excisional surgery in the management of pulmonary tuberculosis is never considered to be a simple or benign procedure. Five deaths have occurred in our last 500 patients who have had pulmonary and/or pleural resections for proved tuberculous lesions. Three occurred at or shortly after pulmonary resection. The two late deaths resulted from cor pulmonale. Thus, in this recent series of 500 patients, the present mortality is 1 per cent, 0.6 per cent being early operative deaths and 0.4 per cent late deaths.

LOW MORTALITY RATE

At this time the mortality rate following pulmonary resection in the treatment of tuberculosis has reached a very low figure. Such is not true when untoward morbidity and complications are estimated after primary surgical measures, although most complications are of little consequence and easily corrected if recognized early and properly managed. Bronchopleural fistula, mixed empyema, operative wound infection, and postoperative spread or dissemination are decidedly on the decrease, thanks to better surgical techniques, ample blood to cover operative and postoperative losses, antimicrobial agents, and the proper timing of the primary operative procedure after complete evaluation of the patient as a whole and of such important local pathologic states as the degree of healing of bronchoscopic viewable segmental bronchial orifices.

Presently we are discovering some of the direct causes of persistent postoperative lung surface leaks and are aware that postoperative infarctions occur much too frequently and may plague the thoracic surgeon. We are fortunate in that we are learning that proper early and aggressive management can cure and thus avert late and more serious complications which in years past often proved fatal.

By and large, we agree with those who contend that patients who harbor drug-resistant organisms and are candidates for excisional therapy should have lobectomy or pneumonectomy, thus avoiding segmental or wedge resections.

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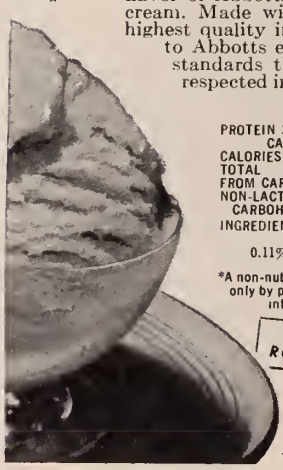
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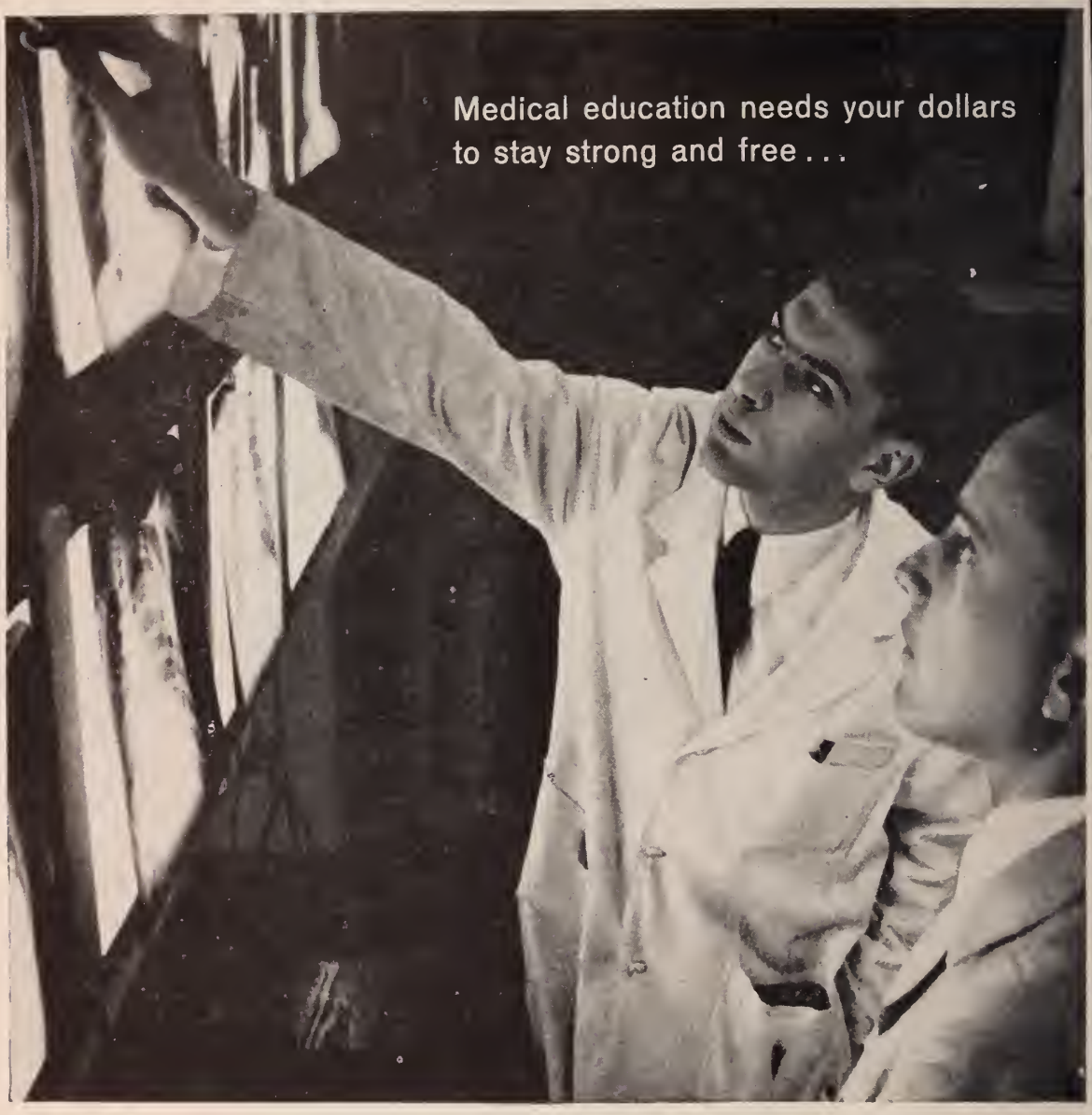
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2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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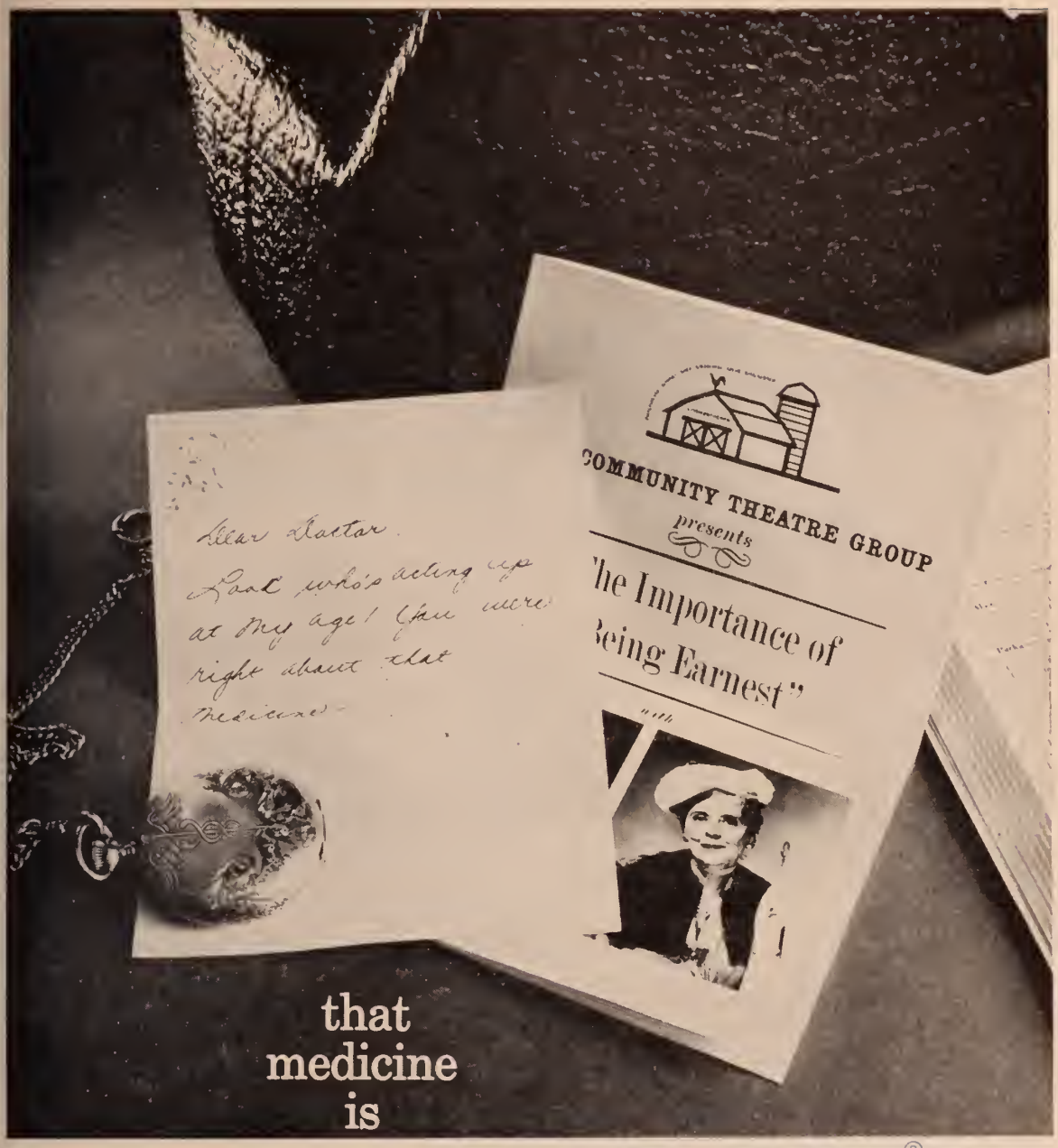
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. In Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism. 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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Q How can syndicates benefit a doctor?

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Q Show an example of how ordinary income converts to long term capital gains.

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Q What is the liability of an investing partner?

A A limited partner risks his investment only, and this investment may range from $2,500 up depending on the cost of a unit of participation.

Q Are partnership interests marketable?

A At a price, a willing seller can always find a willing buyer, thus partnership interests are marketable. Many investment firms, such as First Jersey Securities Corporation, have created a secondary market for the resale of syndication units.

Q Who is the typical syndicate investor and how much has been invested in syndicates to date?

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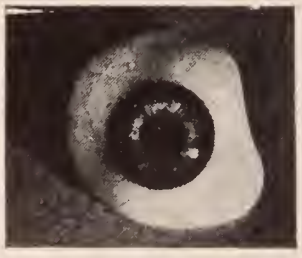
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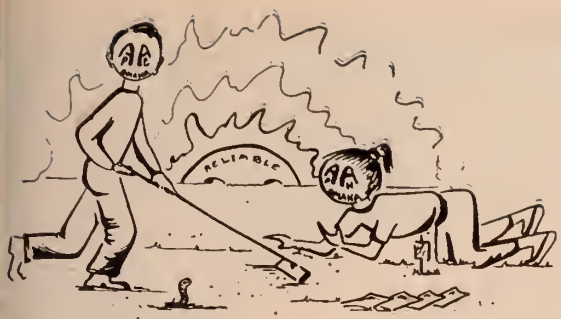
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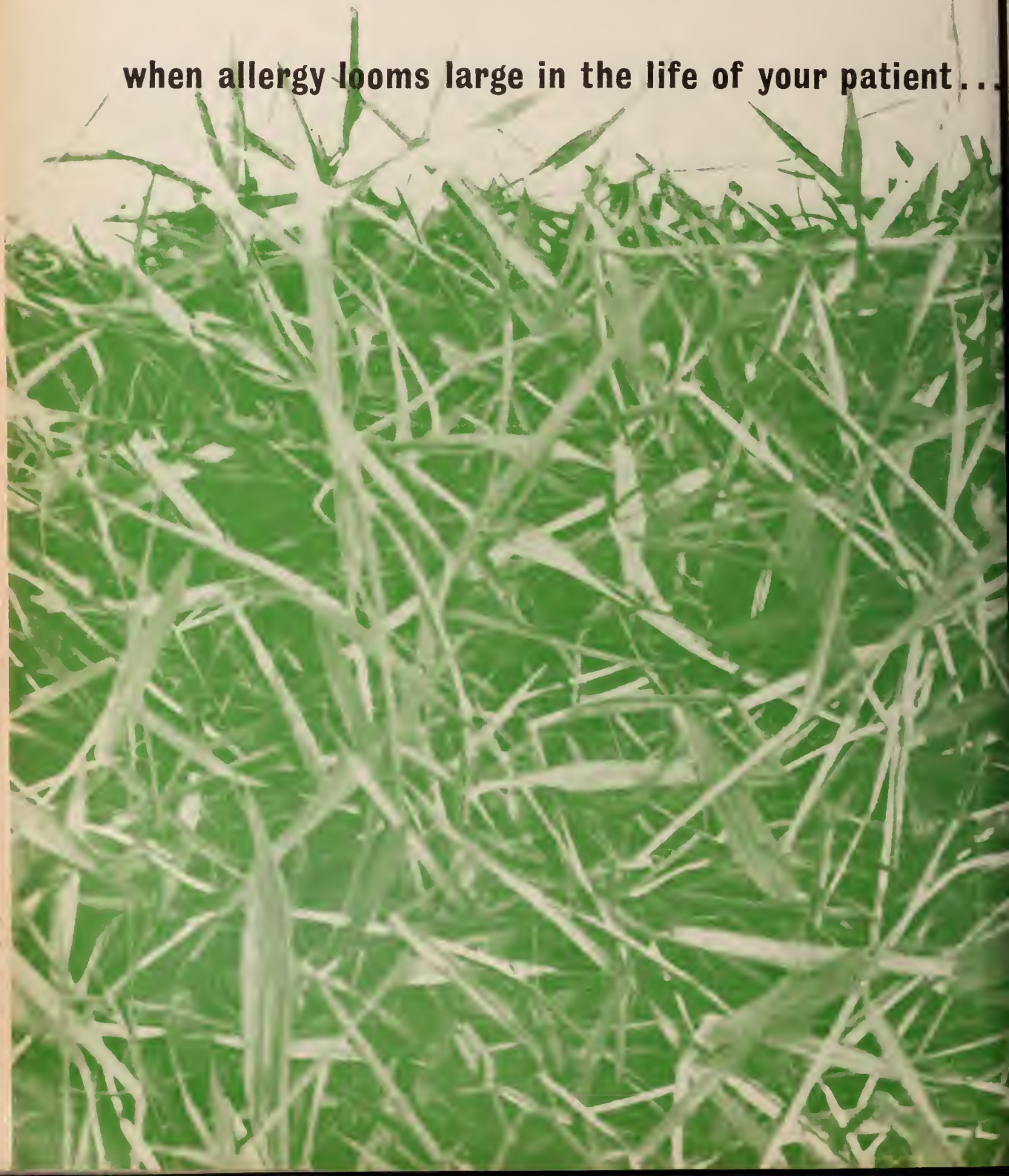
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Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 58, NO. 6 JUNE, 1961 Subscriptions, $3.00 per Year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

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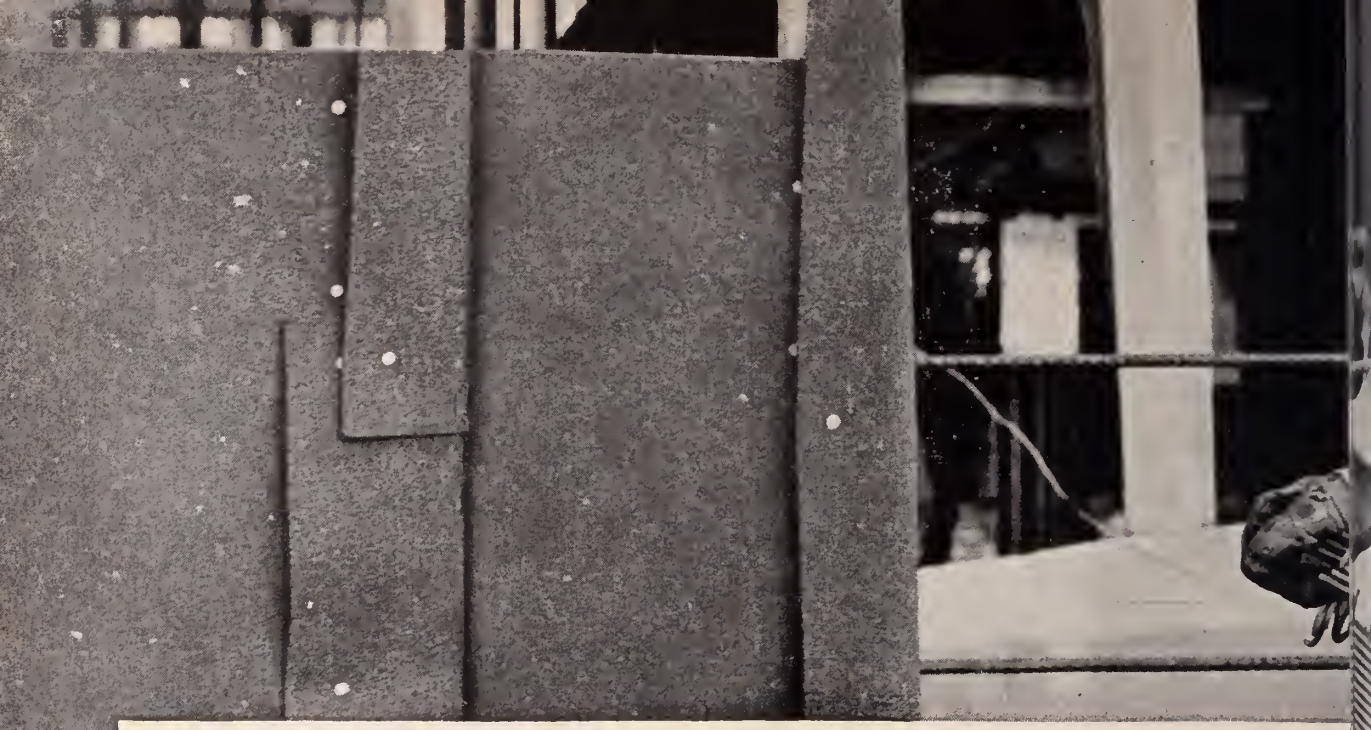
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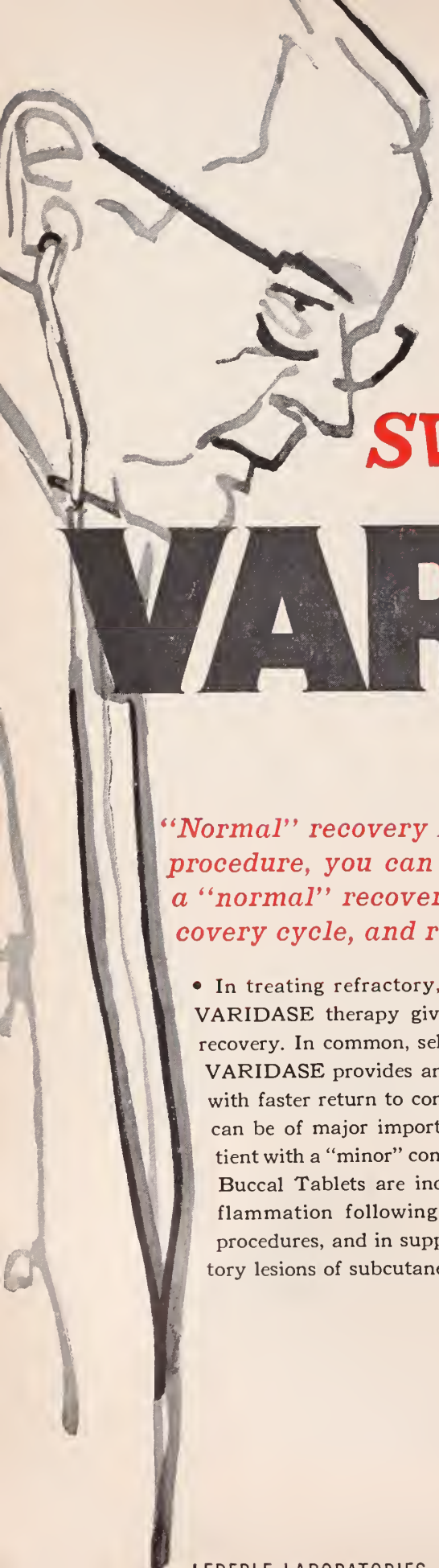
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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council. Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A. Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

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8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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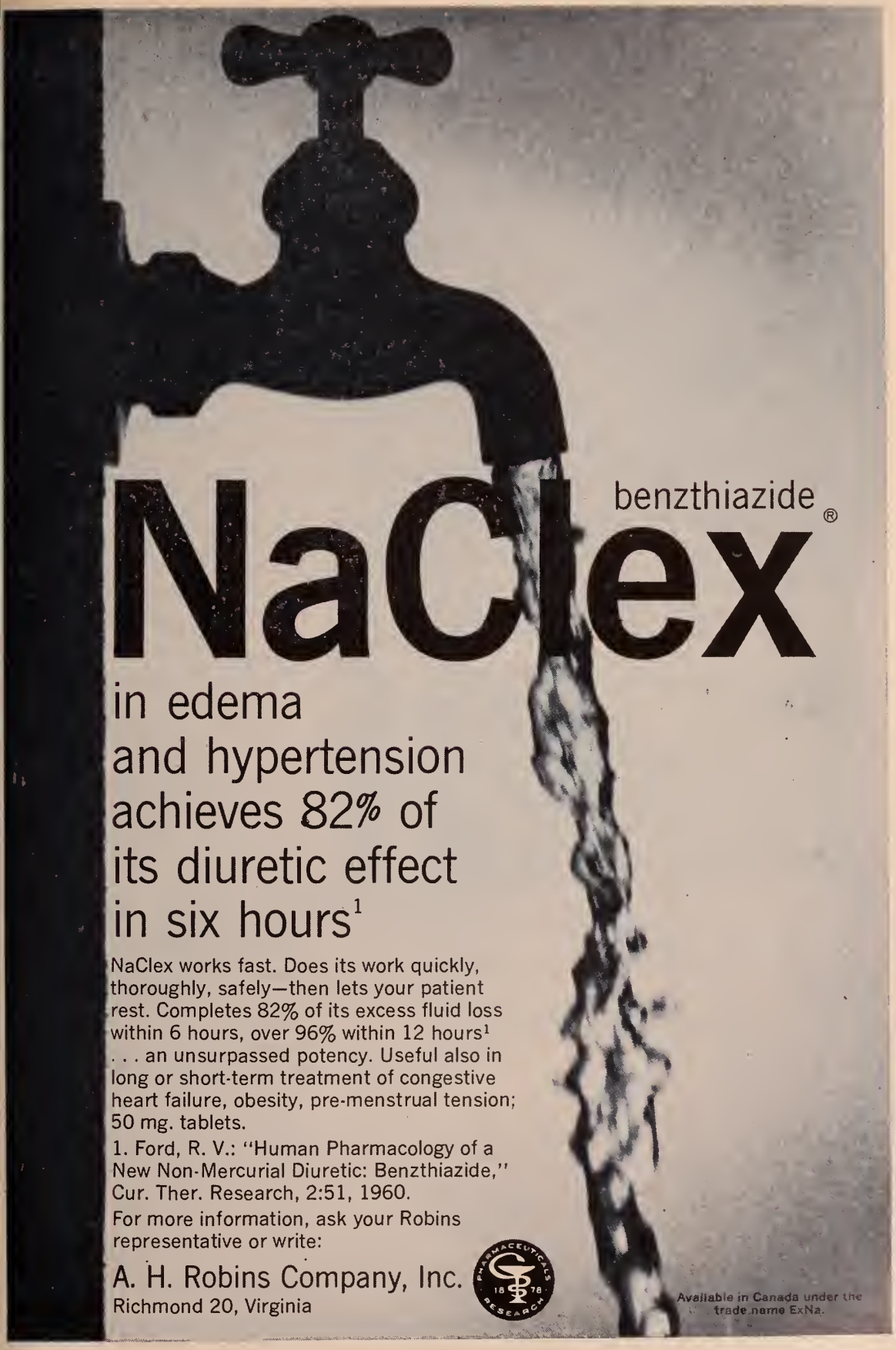
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.

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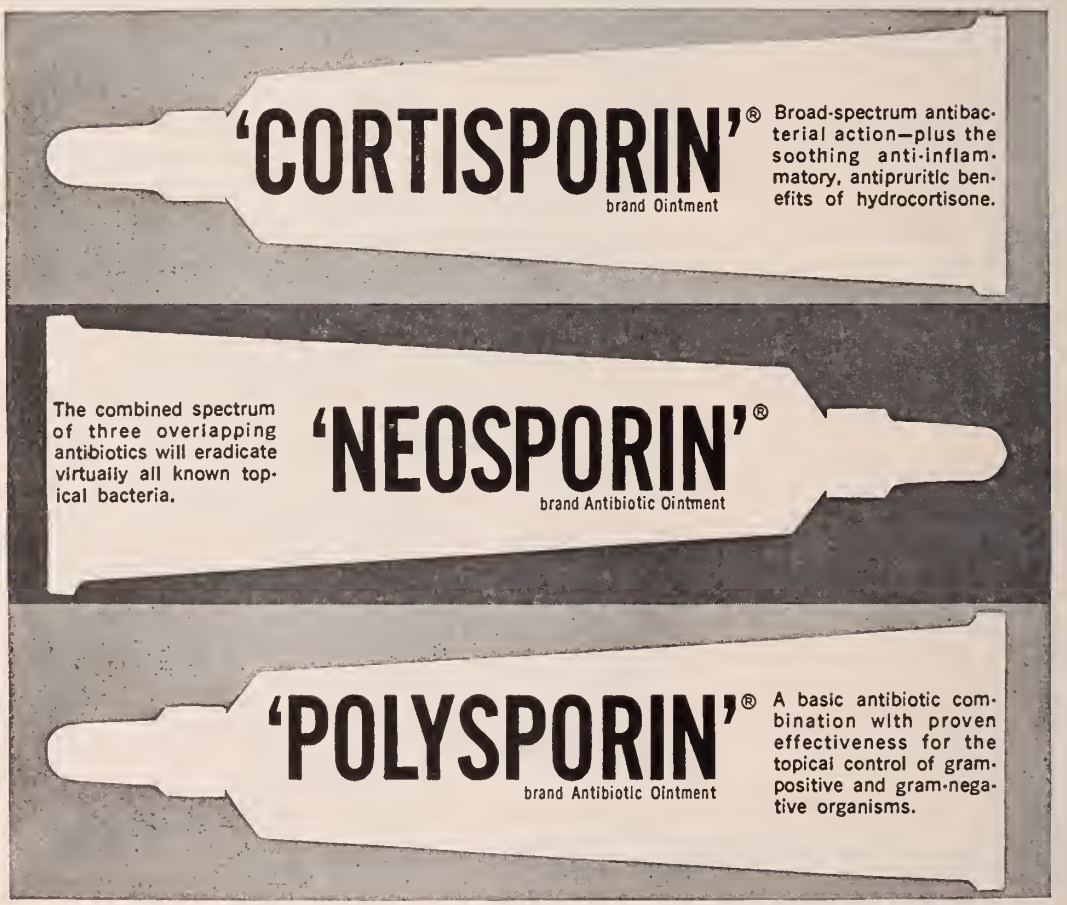
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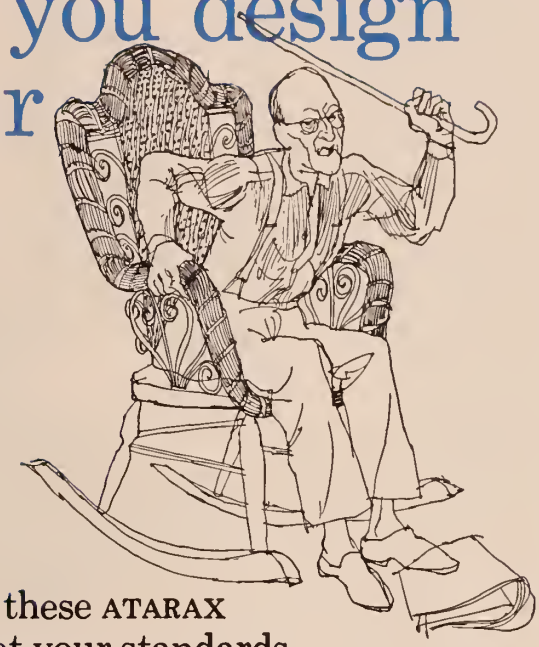
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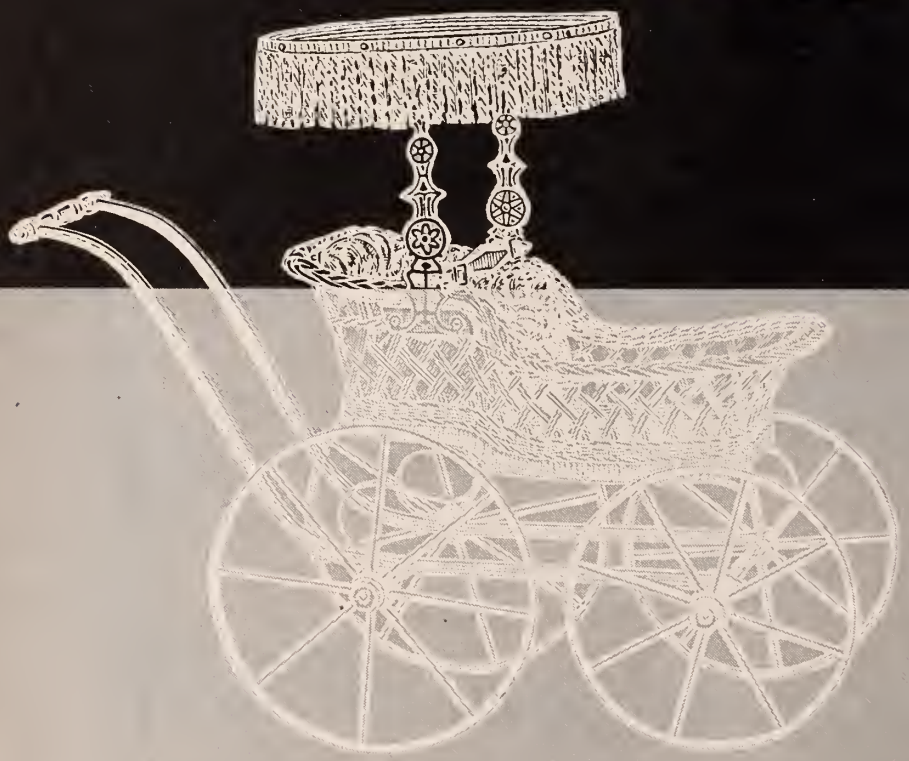
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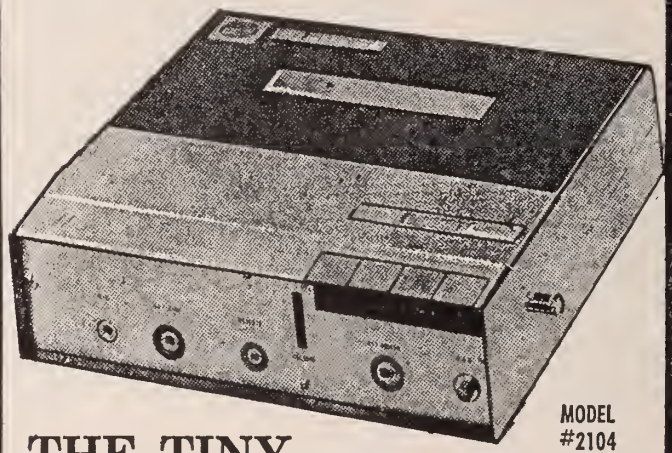
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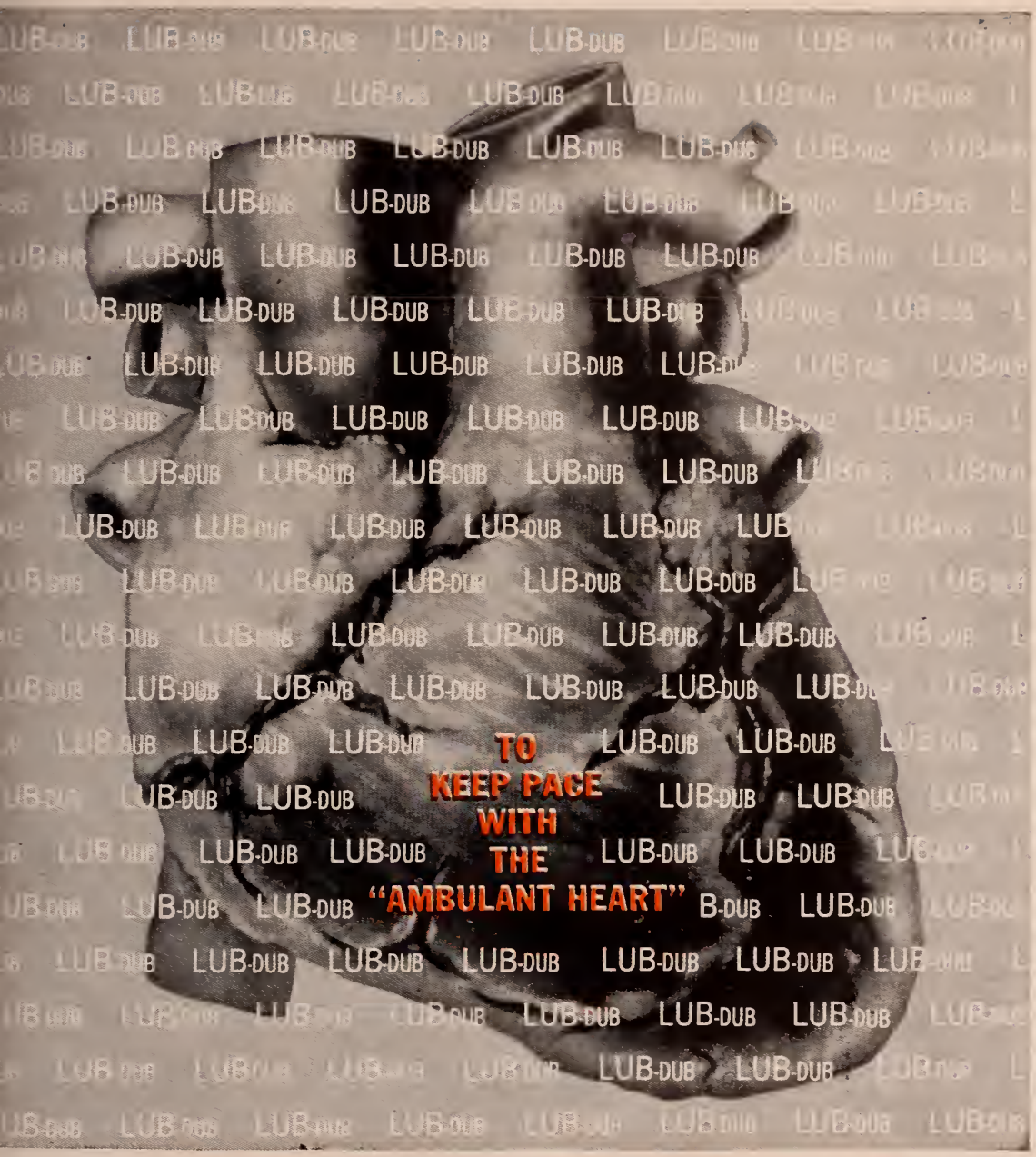
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In mild to moderate decompensation, DIAMOX closely matches diuretic action to diuretic needs. Gentle removal of water is achieved without distorting normal electrolyte ratios. A single morning dose provides comfortable, self-limiting daytime action and nighttime rest. Tablets of 250 mg. Parenteral, vials of 500 mg.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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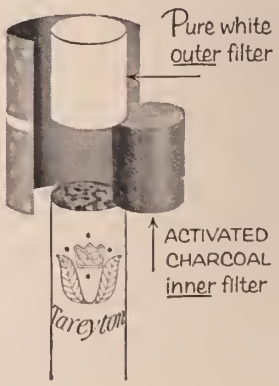
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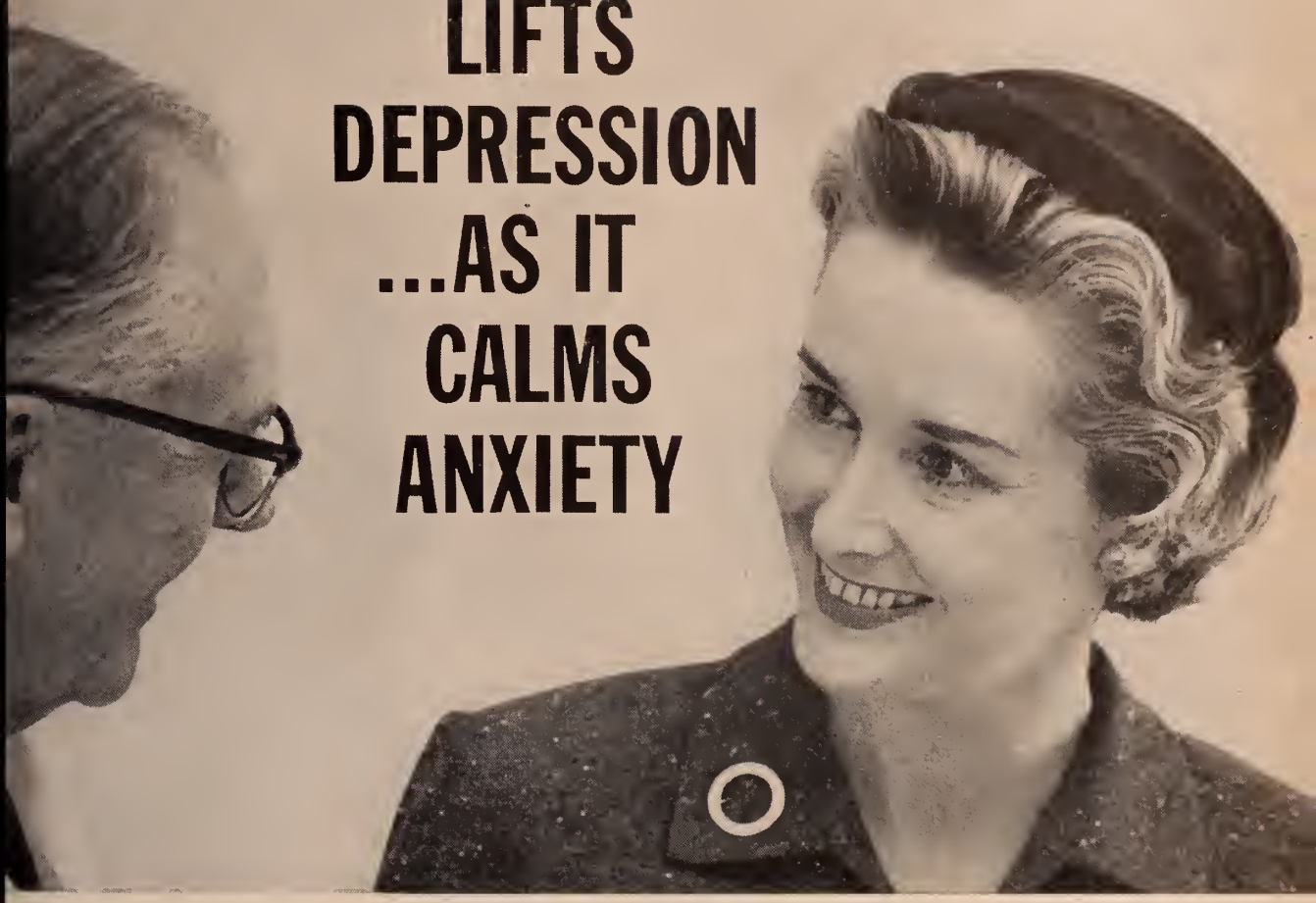
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"I feel like my old self again!" Thanks to your balanced Deprol therapy, her depression has lifted and her mood has brightened up – while her anxiety and tension have been calmed down. She sleeps better, eats better, and normal drive and interest have replaced her emotional fatigue.

Brightens up the mood, brings down tension

Deprol's balanced action avoids "seesaw" effects of energizers and amphetamines. While energizers and amphetamines may stimulate the patient – *they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation – *they often deepen depression and emotional fatigue.*

These "seesaw" effects are avoided with Deprol. It lifts depression as it calms anxiety – a balanced action that brightens up the mood, brings down tension, and relieves insomnia, anorexia and emotional fatigue.

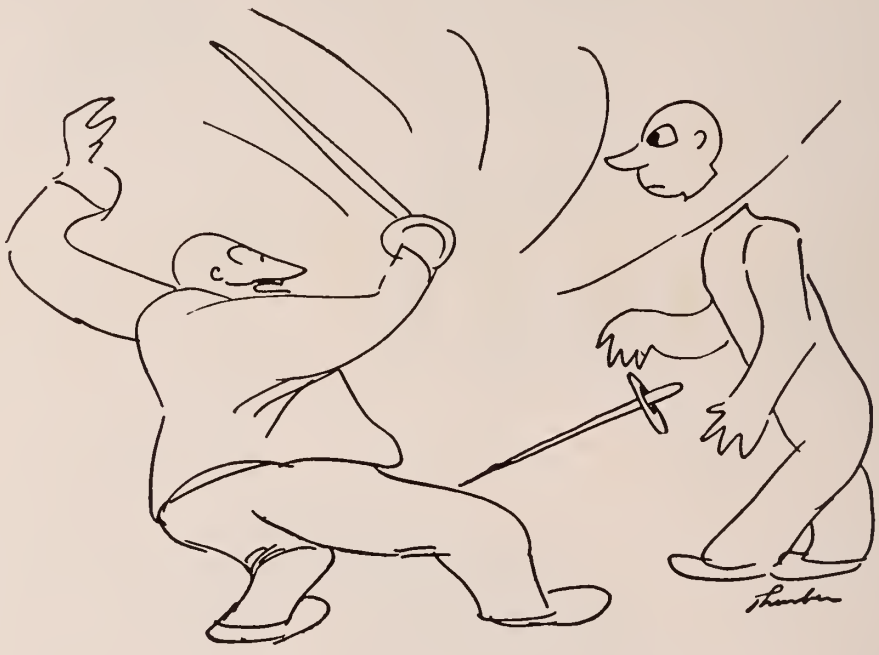
Acts rapidly – you see improvement in a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly – *often within a few days.* Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely – no danger of liver or blood damage. Deprol does not cause liver toxicity, anemia, hypotension, psychotic reactions or changes in sexual function – frequently reported with other drugs.

▲Deprol▲®

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d.
Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate
Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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How Trancoprin relieves pain: Because most pain is accompanied by muscle spasm and tension, good medical practice suggests use of an analgesic that will relax skeletal muscles as well as dim pain perception. Such an analgesic is Trancoprin — a combination of aspirin and Trancopal®, a proved, safe, skeletal muscle relaxant and tranquilizer. Trancoprin can be prescribed for any pain, except pain of such severity that a narcotic is needed.

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to replace skipped meals



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a nutritious meal, ready to drink

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Nutrament liquid requires no special preparation. mooth texture and appealing taste of Nutrament ake it readily acceptable. Equally delicious served ot or cold. Nutrament also has a high satiety value.

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n 12½ fl. oz. cans, chocolate and vanilla flavors. onveniently available at drug and food stores.

offers a scientifically balanced ratio of carbohydrate, protein, and fat. Each 12½ fl. oz. can of Nutrament liquid provides 400 calories. Caloric distribution: protein–20% (20 Gm.); carbohydrate–50% (50 Gm.); fat–30% (13.3 Gm.); plus the following vitamins and minerals:

		% MDR
Vitamin A (U.S.P. Units)	1250	30
Vitamin D (U.S.P. Units)	125	30
Vitamin C, mg.	50	166
Thiamine, mg.	0.5	50
Riboflavin, mg.	0.6	50
Niacinamide, mg.	5	50
Calcium, Gm.	0.5	67
Phosphorus, Gm.	0.4	53
Iron, mg.	4	40
Iodine, mcg.	60	60

Vitamin E (Int. Units)	2.5
Pyridoxine, mg.	0.4
Vitamin B_{12}, mcg.	0.5
Calcium pantothenate, mg.	2
Sodium, Gm.	0.2
Potassium, Gm.	0.9
Copper, mg.	0.5
Manganese, mg.	1
Fiber, Gm.	0.55

ingredients: Whole milk, skim milk, sugar, soy flour, Dextri-Maltose® (maltose and dextrins derived from enzymic action of choice barley malt on selected corn flour), starch, chondrus extract, sodium alginate, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, niacinamide, ferrous sulfate, sodium iodide, *d*-alpha-tocopheryl acetate, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, salt, cupric carbonate, manganese sulfate, cocoa and/or imitation vanilla flavor.

references: (1) Nelson, W. E.: Textbook of Pediatrics, ed. 7, Philadelphia, W. B. Saunders Company, pp. 231-233, 1959. (2) Parrott, R. H., and Nelson, W. E.: *ibid.*, p. 759. (3) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (4) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (5) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960.

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Complete Cholesterol Depressant Menus and Recipe Book

A new, authoritative patient-aid . . . for professional distribution only

Now available for use in your practice from The Wesson People . . . easy-to-use manual of 40 pages, including all necessary diet instructions . . . menus, recipes, shopping and cooking guidance . . . all worked out for you . . . so arranged and printed that you have only to check the desired daily calorie level before giving the book to your patient.

You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

NRC Standards fulfilled. Each menu has been calculated to provide the proper daily allowance of proteins, vitamins and other nutrients as recommended by the Food and Nutrition Board of the National Research Council.

Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

Variety and appetite appeal for patient are built into the menu plan to an extent not previously accomplished. Alternate choices for main dishes minimize monotony, encourage the patient to follow closely the menu plan you specify.

Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

Dietary fat is controlled so that approximately 36% of the total calories are derived from fat and at least 40% of these fat calories are from poly-unsaturated components (linoleates) as found in pure vegetable oil. The replacement of saturated dietary fat by this percentage of poly-unsaturated fat has been found in clinical studies most effective in the reduction of serum cholesterol and in its maintenance at desirable levels. More liberal menus are provided for maintenance after the patient's progress indicates that desired therapeutic results have been accomplished.

Family meal preparation is simplified. The menus are planned around favorite foods having wide appetite appeal for all members of the household. Patients can entertain in comfort—enjoy cakes, cookies, snacks, prepared with recipes which meet medical requirements.

A high degree of satiety is achieved even at the lower calorie levels, because Wesson provides an unexcelled source of concentrated, slow-burning food energy.

Adaptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important. Calories, which must be supplied from fat when the carbohydrate intake is limited, are provided by desirable poly-unsaturated vegetable oil.

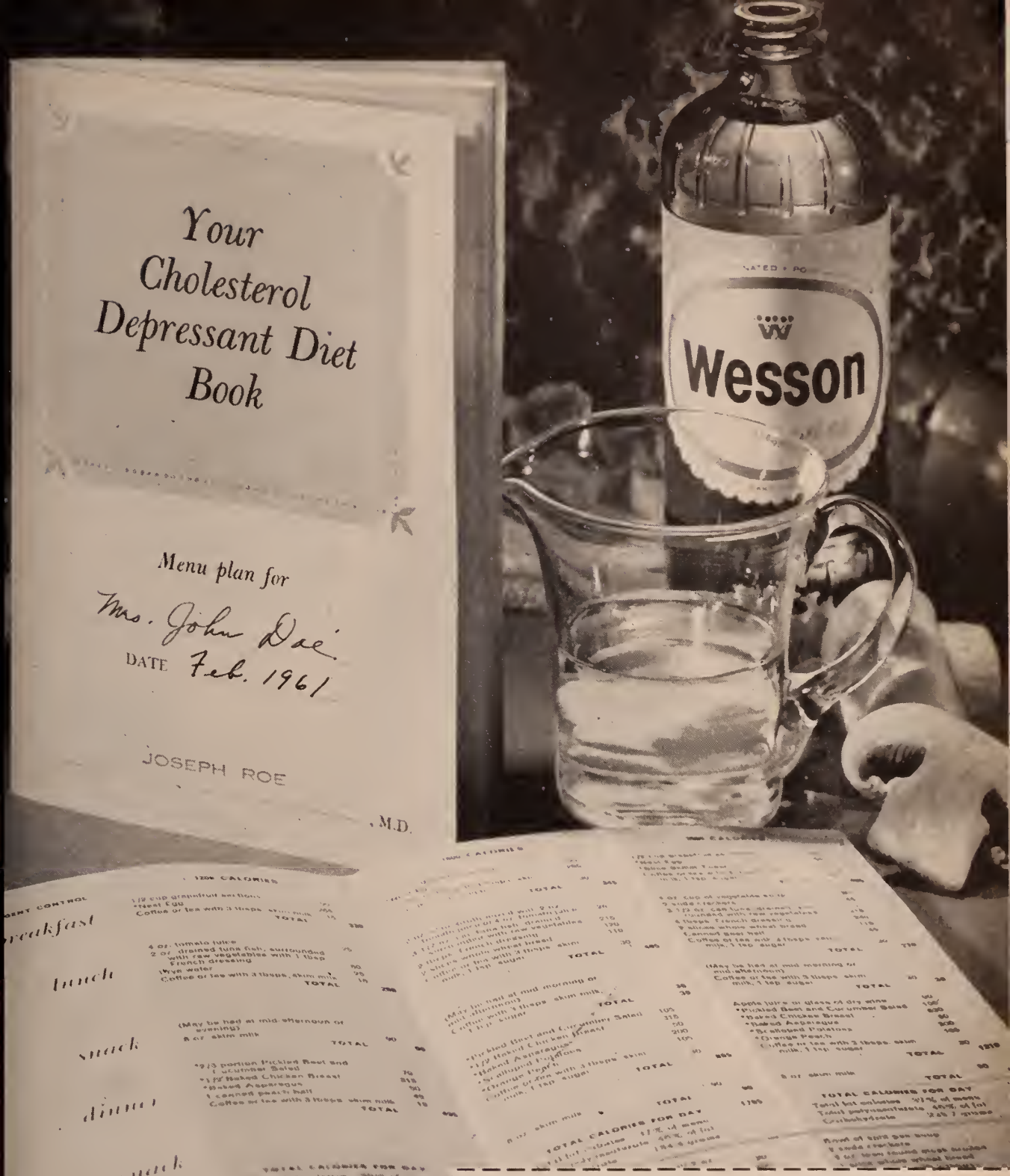
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Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
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ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in inflammatory and allergic dermatoses.

But ARISTOCORT has also opened up new areas of therapy for selected patients who could otherwise not be given corticosteroids.

for example:

SPECIAL PROBLEM: EDEMA DUE TO SODIUM AND WATER RETENTION

In patients with edema induced by the earlier corticosteroids or from other causes, diuresis and sodium loss often occurs with triamcinolone. (Fernandez-Herlihy, L.: *M. Clin. North America* 44:509 [Mar.] 1960.)

SPECIAL PROBLEM: APPETITE STIMULATION AND WEIGHT GAIN

In contrast to the heightened craving for food sometimes seen with other corticosteroid compounds, appetite was unaffected by triamcinolone. (Cahn, M. M., and Levy, E. J.: *Am. Pract. & Digest Treat.* 10:993 [June] 1959.)

SPECIAL PROBLEM: HYPERTENSION

When ARISTOCORT was given to patients with dermatologic disorders for long periods, there were no significant changes in blood pressure. (Kanof, N. B.; Blau, S.; Fleischmajer, R., and Meister, B.: *A.M.A. Arch. Dermat.* 79:631 [June] 1959.)

SPECIAL PROBLEM: PSYCHIC STIMULATION AND INSOMNIA

Ideally, corticosteroid therapy ought not to add to the psychic component in dermatologic disorders, nor induce insomnia which will intensify the patient's itching and irritation. ARISTOCORT Triamcinolone has been singled out for its remarkably low incidence of psychic irritation and insomnia. (McGavack, T. H.: *Nebraska M. J.* 44:377 [Aug.] 1959; Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: SEVERE CARDIAC DISEASE

Elderly patients with pulmonary emphysema due to impending heart failure who required corticosteroid therapy showed that triamcinolone could be employed with benefit and relative safety. (McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 [Dec.] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic and inflammatory dermatoses, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white). Also available—syrup, parenteral and various topical forms.

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Rapid and Prolonged
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RELIEF OF ANXIETY AND TENSION

Protection Against
CAPILLARY FRAGILITY

ADULT DOSAGE: As a hypotensive, one or two tablets 2 or 3 times daily. Usual maintenance dose one tablet twice daily. Doses in excess of 2 tablets daily should not be used in patients with a history of mental depression, peptic ulcer or ulcerative colitis.

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Each tablet contains Reserpine 0.1 mg.
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Side Effects: DIMETANE is usually well tolerated. Occasional mild drowsiness may be encountered. If desired, this may be offset by small doses of methamphetamine. Until known that the patient does not become drowsy, he should be cautioned against engaging in mechanical operations which require alertness.

Contraindications: Sensitivity to antihistamines. *Also Available:* Dimetane-Ten Injectable (10 mg./cc.) or Dimetane-100 Injectable (100 mg./cc.)

References: 1. Lineback, M.: The Eye, Ear, Nose and Throat Monthly *39*:342 (April) 1960. 2. Fuchs, A. M. and Maurer, M. L.: New York J. Med. *59*:3060 (August 15) 1959. 3. Kreindler, L. *et al.*: Antibiotic Med. and Clin. Therapy *6*:28 (January) 1959. 4. Schiller, I. W. and Lowell, F. C.: New England J. Med. *261*:478 (September 3) 1959. 5. Edmonds, J. T.: The Laryngoscope *69*:1213 (September) 1959. 6. Horstman, H. A.: Am. Pract. & Digest Treat. *10*:96 (January) 1959.

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Brāsivol has a gentle abrasive action that attacks the acne lesion simply and directly. It maintains the mild desquamation so essential to the successful acne regime. Helps open plugged pores, reduce pustules and blackheads, control oiliness. Helps minimize postacne scars. The patient simply applies Brāsivol abrasive cleanser 2 or 3 times daily, and rinses. Ritual helps relieve urge to squeeze pimples. Cooperation is enhanced because results are readily seen and felt. Safety and success are supported in over 10 years of clinical studies on thousands of acne cases. Brāsivol (pat. pend.) contains precisely sized abrasive particles (fused aluminum oxide) and hexachlorophene 1%, in a detergent and drying base. Compatible with other therapeutic measures.

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REFERENCES:

SAPERSTEIN, R. B.: Treatment of Acne with Long Term Continuous Abrasion. A.M.A. Archives of Derm. 81: 601, April 1960.

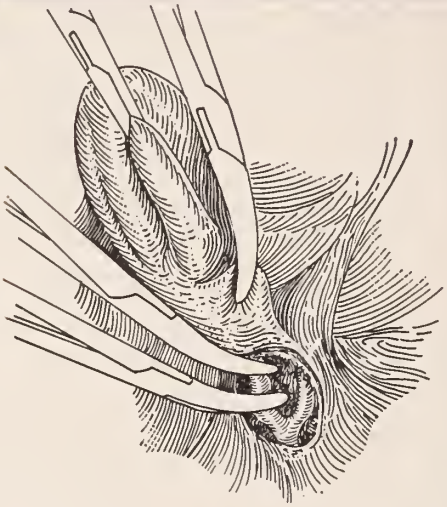
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SULZBERGER, M. B. & WITTEN, V. H.: The Management of Acne Today. Med. Clinics of No. America, 43:3, May 1959.

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HOW MAY A PATIENT BE REASSURED THAT REMOVAL OF HIS GALLBLADDER WILL NOT SERIOUSLY IMPAIR HIS DIGESTIVE ABILITY?

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Source: Farris, J. M., and Smith, G. K.: M. Clin. North America *43*:1133 (July) 1959.

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It's good nutrition to encourage people to drink orange juice. It makes good sense to persuade them to drink orange juice that you *know* tastes good, has the right sugar-acid ratio, and is packed full of nutritionally important vitamin C.

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Heart disease, cancer, mental illness — everyone knows the nation's three major medical problems. Do you know that alcoholism ranks fourth? In the state of New Jersey there are at least 232,000 alcoholics. These people need medical help. No one is in a better position to initiate and supervise a program of rehabilitation than the physician who enjoys the confidence of the patient or the patient's family.

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During and after an acute alcoholic episode, Librium relieves anxiety, agitation and hyperactivity, induces restful sleep, awakens the patient's desire for solid food and helps to control withdrawal symptoms. The complications of chronic alcoholism, including hallucinations and delirium tremens, can often be alleviated with Librium.

During the rehabilitation period, Librium makes the patient more accessible, strengthening the physician-patient relationship. Librium therapy helps to reduce the patient's need for alcohol by affording a constructive approach to his underlying personality disorders.

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Editorials • • •

Meet Ralph Buchanan



The small town doctor is still the proper image for the good physician—the well-rounded family medical adviser, part of his community's elite, the good citizen in all dimensions. Ralph McKay Lashelle Buchanan typifies this so well, he might have been its modern model. Born in St. Clair, Pennsylvania, in 1907, he was the youngest boy in a fine, old-fashioned, 7-son family. His high school training was at the well known Mercersburg Academy, and his bachelor of science degree was awarded by Lafayette in 1929. Dr. Buchanan then entered Hahnemann Medical College and received his M.D. there in 1933. He interned at the Memorial Hospital in Abington, Pennsylvania and did graduate work at the medical school attached to Cook County Hospital in Chicago, later at the Bellevue Postgraduate Medical Center in New York City. This carried him to 1936, at which time, luckily for us, he decided to move across the Delaware River and settle in New Jersey. Except for his four-year tour of Navy duty during the second World War, he served the

PUBLISHED MONTHLY SINCE 1904

Under the direction of the Committee on Publication

FRED B. ROGERS, M.D., *Chairman*

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Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.

Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.

Send all communications for publication to P.O. BOX 904, Trenton 5, N. J. — Telephone EXport 4-3154

Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 682

VOL. 58, NO. 6 JUNE, 1961

Subscriptions, $3.00 per year
Single Copies, 30 Cents

good people of Phillipsburg continually since 1936.

Married to the former Grace S. Albinson, he is the father of a fine quartet—two of each kind. Dr. Buchanan is active in organizational affairs. He has been president of our Warren County Medical Society and also of the Industrial Medical Association of New Jersey. He was, at one time, treasurer of that Association, and indeed, is generally considered one of the national leaders in the growing field of industrial medicine. He is now president of the State Board of Medical Examiners of New Jersey and Medical Director of the Phillipsburg works of Ingersoll-Rand. He has held top office in many civic and fraternal organizations, and is a respected spokesman for his two great interests—small town medical practice and industrial medicine.

In this age of big city medicine and overspecialization, it is good to have as our standard bearer one who speaks so eloquently for the grass roots as well as for the more glamorous refinements of modern medicine. Dr. Buchanan's rapid, but soft-spoken advancement from a neophyte family doctor in 1936 to the number one leader in the country's oldest medical society in 1961 is a true measure of the man.

And now is the chance for all New Jersey medicine to meet Ralph Buchanan!

When is a Doctor Not a Doctor?

Last year 6500 M.D. degrees and 3100 D.D.S. degrees were awarded in the United States. In that year, however, 11,000 other doctors' degrees were granted.[1] Thus, only 30 per cent of last year's doctor crop were physicians. The nonmedical doctors ranged from those in agronomy to those in zoology; they included the clergyman's D.D. and the Ed.D. in dramatic arts; there were Ph.D.'s in textiles and in architecture.

Lexicographically, we have no complaint. The word *doctor* comes from "docere" meaning to teach; so every teacher is, in this sense; a "doctor." Also, the word *docile* (literally: teachable) has the same root. So perhaps we should be docile about the use of our title by linguists, librarians and lawyers (J.D. degree). Indeed, the unabridged dictionary[2] will deflate any of us. This dictionary was edited by W. Allan Neilson who is a quadruple threat doctor: LL.D.; Ph.D.; L.H.D. and Litt. D. On page 763 of this edition,[2] Dr. Neilson defines doctors, as among other things: a teacher; a cook in a lumber camp; a wizard; a makeshift mechanical contrivance; a cool breeze; brown sherry; a donkey engine; a knife for scraping the dough in a mixing machine; and one of a pair of loaded dice.

So, our title to the word is not at all clear. Both history and semantics recognize other kinds of doctors.

Even in medicine there are some curious overtones to the title. In many European countries, the medical practitioner gets, in effect, a bachelor's degree after four years of medical school. The "doctor" is awarded only to the academic elite who pursue postgraduate studies. To a European, suggests Stowell,[3] American schools that award a doctorate after only four years "must seem like diploma mills." In many of the European professional schools, the M.D. has the meaning that a Ph.D. *plus* an M.D. would have in our country.

We have been warned that we must not begrudge the title "doctor" to the nonmedical scholars who have earned it. Thus, Stowell[3] points out that:

"Dentists certainly are not impressed by the reference to 'doctors and dentists.' Some physical

1 World Almanac for 1961. Page 508.
2 Webster's New International Dictionary, Ed. 2. Merriam Company 1938. Springfield, Massachusetts.
3 Stowell, R. E. (M.D.): Bulletin of the College of American Pathologists, 14:155 (December 1960).

scientists retaliate with 'Is he a physician or a scientist?'

"Should learned professors in this country who train many for doctorate degrees in fields other than medicine not be addressed as Doctor? In contrast to many other countries where the title of professor is most highly regarded by the general population, in the United States many regard it as a joke. By some, the egghead is deemed a 'sucker' who doesn't have enough sense to capitalize fully upon his potential earnings. Isn't there some confusion of values and meanings of these titles? As physicians, we should recognize that in many other fields besides medicine, academic degrees of doctor are given and that we should extend to the holders of these degrees the same courtesy of title which we expect for our own. Regardless of the extent to which we practice, investigate, or instruct, we should conduct ourselves as learned men, teachers, and scientists in the highest tradition of the academic title of Doctor."

This plea for tolerance is well intended and common courtesy would seem to require us to be as careful about using the proper handle in identifying our scientific and academic brethren as we are in addressing each other. To be sure, it may take a year or two longer to earn the M.D. than to earn an Ed.D. or a Ph.D. or to become a Doctor of Sacred Theology. But the other kind of doctor has legitimately earned his degree. And since the word itself ("doctor") has no basic medical heritage, we have—in theory—no right to a monoply of it.

In a more realistic sense though—at least in the U.S.A.—the word "doctor" unless otherwise specified is taken to mean a physician. In Britain, the practitioner is usually an M.B. and a C.M. (bachelor of medicine and master of surgery) and in the academic sense not a "doctor" at all. However, even there, the word 'doctor' is understood to mean a medical practitioner of any degree. If we do not have a historical or lexicographic monopoly of "doctor," we have, at least an easement [4] on it by long and honorable usage.

It is sometimes suggested that we clarify our status in two ways: by insisting on the M.D. after the name instead of the "Dr." before it; and by referring to each other as "physicians" rather than as "doctors." If we could learn to do that, it would reduce the confusion, though it sounds awkward to say: "I hear that Mary is going with a physician"; or even "Joe is a darn good physician."

As the current doctor-making (not physician making) machinery continues to purr in high gear, we are, in this country, manufacturing 7 non-physician doctors for every 3 M.D.'s. At this rate we may lose our semantic monopoly.

Still, when the man on the stage pleads: "Is there a doctor in the house?" we know what he means.

4. This concern with dictionaries is becoming an obsession. According to the same dictionary (*op. cit.* 2) an easement is "a right of use falling short of ownership."

Some Little Bug Will Get You Yet

As the nineteenth century came to a close, medicine was dominated by the "germ theory" of disease. Referring to the period 1870-1880, Haggard [1] says ". . . we finally reach the decade in which the bacterial cause of infection was established—the most far reaching discovery in all human progress!"

Strong words those—the most far reaching discovery in all human progress; not just in the history of medicine, says Dr. Haggard, but in all human progress. And so it seemed then. For every disease, there was surely somewhere a bacterium. For every germ, there would one day be found a serum or antitoxin; for every diagnosis, a bacteriologic test. You could survive indefinitely if you could escape the bacteria . . . but, in the words of the turn-of-the-century song, "Some little bug will get you yet"—you were mortal, indeed, only because some spirillum, coccus or bacillus would finally invade you. (Those were the simple

1. Haggard, H. W.: Mystery, Magic and Medicine. Garden City 1933, Doubleday, Doran. Page 125.

days when these were the only bacteria; still in the unopened books of time were the fancier classifications like Escherichia, Pasteurella, Salmonellae and Alcaligenes).

In a sense it was fortunate for the history of medicine, that the rapid development of bacteriology occurred in the century when infectious diseases rode the land like the Four Horsemen. The flowering of this science opened the door to methods of infection control and gave preventive medicine its first triumph.

In the first third of our century, medical leaders came from those trained at the end of the nineteenth century—the century of bacteriology. So among them was the hope that somewhere would be found the bacterium of cancer. Give us a better microscope or a sharper stain was the cry, and we will find some Spirillum Carcinomatis. Schizophrenia looked like the deterioration of senility—and it was called dementia *precox* to counterbalance demential *dementia*. The search was on for some schizococcus. High blood pressure—arthritis—arteriosclerosis—here, too it was thought, bacteria would be found and antitoxins developed.

The effectiveness of bacteriologic and preventive-infectious programs is dramatically illustrated by the astonishing decline in death rates from infectious diseases during the first half of the twentieth century. In that period, deaths from malignancy sky-rocketted from 64 to 150 per hundred thousand; but look what happened to infectious diseases: (all rates are per 100,000):

Influenza—from 202 to 28
Tuberculosis—from 194 to 8
Syphilis—from 12 to 2
Measles—from 13 to 0.2
Whooping cough—from 12 to 0.1
Typhoid—from 31 to 0
Diphtheria—from 41 to 0

But we have become the victims of our own success. Man is mortal and must die from something. As we push back the tide of infection, we allow the chronic diseases to come in. The 1903 baby who died from diphtheria would not develop a carcinoma at the age of 70.

Even within the field of bacteriology, there has been change rather than decline. As Dubos [2] puts it:

"Most frequently today, problems arise not from the highly virulent pathogens, but rather from the common microbes that are ubiquitous in our environment, and even in our bodies, and that had long been assumed to be essentially harmless. These ubiquitous microbes become agents of disease only when the general resistance of the body has been decreased by disturbances in individual physiology or in social conditions.

"Susceptibility to tuberculosis is increased by certain nutritional deficiencies, by inadequate protein nutrition in particular.

"It is most unlikely that drugs alone, or drugs supplemented by vaccination, can control tuberculosis in the underprivileged countries of the world as long as their nutritional status has not been raised to a reasonable level.

"In view of these facts, I find it difficult to believe that the solution of the problem of infectious disease can be based only on an endless search for new types of vaccination, or new types of drugs, to meet each emergency as it arises. We must look for other avenues of approach, probably different ones from those based on the concepts of specific etiology."

We search now, not simply in the microcosm of the glass slide, but in the macrocosm of the world around us. Disease, we know, relates to diet, to emotions, to the pollens in the air and to the anxieties in the air; it relates to tension and stress and to the pace of life; to the wear and tear of the human machine; to overt hostility and to repressed hostility; to hate and aggression.

How simple it all seems now when it was just a matter of finding the exact germ and the right stain and the effective serum. Some little bug will get you yet—but it won't be the once powerful bacterium. *Pasteurella pestis* (in our day it was *Bacillus pestis*) is still no laughing matter. But the threatening plague now is not the kind for which the bacteriologists will find an antitoxin.

2 Dubos, Rene J.: Journal of the American Medical Association, Oct. 1, 1960.

WILLIAM F. HAYNES, JR., M.D.

Princeton

A New and Successful Treatment for Barbiturate Intoxication

Report of Eight Cases

Three cases of barbiturate intoxication were treated by nonspecific, supportive measures. Five were treated with methylglutarimide and phenylthiazole.

BARBITURATE overdosage classically has been treated by such general measures as gastric lavage, maintenance of an adequate airway, administration of oxygen, parenteral feedings, prophylactic antibiotics, and observation of the patient's vital signs. Many physicians allow the patient to remain comatose until the effects of the drug wear off. Others prefer to hasten recovery by the use of picrotoxin or other analeptic drugs.

A new preparation, methylglutarimide,* has been found effective in restoring the circulation and in bringing about a rapid rise in the level of consciousness in barbiturate intoxication.[1,2,3] Methylglutarimide* has been reported even more effective when used in conjunction with another new drug, phenylthiazole.† The former seems to act as a direct antagonist to barbiturate preparations. The manner in which this is accomplished has not been defined. Phenylthiazole† is a weak barbiturate antagonist. Its chief effect appears to lie in stimulation of the respiratory center, and its ability to potentiate the more powerful barbiturate antagonist, methylglutarimide.*

The present report summarizes eight cases of barbiturate intoxication recently encountered in St. Luke's Hospital in New York City. Three were treated by general, supportive measures. The other five illustrate the dramatic rate of recovery in the level of consciousness and physiologic status following administration of methylglutarimide* and phenylthiazole.†

Stage 2 was used as the criterion for recovery. In the management of the comatose patient, *quantitative* blood barbiturate levels are not routinely done in most hospitals and probably would add little as far as treatment is concerned. In contrast, the *qualitative* determination of barbiturate in the blood aids greatly in diagnosing the comatose patient, and may determine the direction therapy is to take.§

TABLE 1.

CLINICAL FINDINGS EXHIBITED BY PATIENTS IN 5 STAGES OF BARBITURATE INTOXICATION

Stage 1:	Awake, competent, and mildly sedated.
Stage 2:	Sedated, reflexes present.†
Stage 3:	Comatose, reflexes present.
Stage 4:	Comatose, no reflexes obtainable.
Stage 5:	Comatose, no reflexes obtainable, with circulatory and/or respiratory difficulty.

*Beta-ethyl-beta methylglutarimide- (Trade name: Megimide) Abbott

†2:4-Diamino-5-phenylthiazole (Trade name: Daptazole) A. and G. Nicholas, Ltd.

§In the eight cases reported herein, the diagnosis of barbiturate intoxication was confirmed by the use of the qualitative method of Goldbaum [8] for the detection of barbiturate in blood and urine.

TABLE 2.

COMPARISON OF RATES OF RECOVERY BETWEEN PATIENTS TREATED WITH SUPPORTIVE MEASURES AND THOSE TREATED WITH METHYLGLUTARIMIDE* AND PHENYLTHIAZOLE†

A. *Patients Treated with General Supportive Methods.*

Case	Stage of Intoxication On Admission	Time Needed To Reach Stage 2
1.	Stage 5	44 hours
2.	Stage 4	22 hours
3.	Stage 3	8 hours

B. *Patients Treated with Methylglutarimide* and Phenylthiazole†.*

Case	Stage of Intoxication On Admission	Time Needed To Reach Stage 2
1.	Stage 4	2 minutes‡
2.	Stage 5	100 minutes
3.	Stage 5	240 minutes
4.	Stage 3	2 minutes
5.	Stage 4	50 minutes

PATIENTS TREATED BY SUPPORTIVE MEASURES ONLY

Case 1. A 39-year old man was admitted to St. Luke's Hospital in coma. His wife said that he had appeared in good spirits at bedtime on the night of admission. She vigorously denied that he had recently been depressed.

Blood pressure at the time of admission was 90/60; pulse rate 96. He was cyanotic and breathing rapidly and shallowly with stertorous rattling inspirations. Signs of trismus and laryngeal spasm were present. Deep tendon reflexes could not be obtained, and he did not respond to painful stimuli. Corneal reflexes were absent. Pupils did not react to light. His clinical status corresponded to Stage 5 of barbiturate intoxication. A gastric lavage was performed, and he was given oxygen and intramuscular ephedrine as well as penicillin prophylactically. Parenteral fluids were administered, and nurses were assigned to observe vital signs at regular intervals. About 44 hours after admission, the patient's condition had improved sufficiently to be classified Stage 2. Stage 1 was reached 68 hours after admission.

Case 2. A 37-year old woman was admitted in coma. Her husband had found her in a stuporous state and mumbling incoherently on the evening of admission. She soon slipped into deep coma. A known alcoholic, she was receiving psychotherapy for depression. She had made two previous attempts at suicide during the past several years.

Blood pressure was 105/75; pulse rate 80; respirations were 14. No pupillary light reflex could be obtained, and the corneal reflexes were absent. Deep tendon reflexes were absent, and there was no response to painful stimuli. She was in Stage 4 intoxication. Parenteral fluids and prophylactice antibiotics were given. Twenty-two hours later, she had recovered sufficiently to be considered in Stage 2. Fifty-six hours after admission, she had reached Stage 1.

Case 3. A 24-year old woman was admitted in coma. She had made at least four previous attempts at suicide in the recent past.

Blood pressure on admission was 125/85; pulse rate was 80. Respirations varied from 10 to 20. Her pupils did not react to light. Patellar clonus and a positive Babinski were noted on the left. She did not respond to painful stimuli or to commands. Deep tendon reflexes were weakly obtainable. She was in Stage 3 intoxication. Spinal fluid was normal. Prophylactic penicillin was administered. Parenteral feedings were instituted after gastric lavage had been done. After 8 hours, her condition had improved to the Stage 2 level. She reached Stage 1 twenty-four hours after admission.

PATIENTS TREATED WITH METHYLGLUTARIMIDE AND PHENYLTHIAZOLE

Case 1. A 51-year old woman was admitted in coma. A diagnosis of lupus erythematosus disseminatus had been made six months previously, and she had been maintained on prednisone therapy without recurrence of symptoms. She had been taking barbiturates for sedation.

Blood pressure at the time of admission was 114/72 and pulse was 80. She was moderately obtunded, responding only by opening her eyes when called by her first name and simultaneously tapped on the sternum. Pupils reacted sluggishly to light. Two hours after admission, she lapsed into deeper coma, *i.e.*, from Stage 3 to Stage 4. Then the pupils no longer reacted to light. Blood pressure fell to 98/60. At this juncture, 10 cubic centimeters (or 50 milligrams) of methylglutarimide* were given intravenously. Two minutes later, she began to cry and talk, and attempted to sit up in bed. She remained in this improved state of consciousness (Stage 2) for 3½ hours and then began to slip back into unresponsiveness (Stage 3). A second dose of 50 milligrams of the drug* was given, and she *immediately* regained consciousness. Vital signs returned to normal, and she remained alert without subsequent relapse.

Case 2. A 45-year old woman was admitted in coma. She was a medical secretary with access to barbiturate drugs. She was known to have been well a few hours previously when she had dinner with her husband.

Blood pressure at the time of admission was 86/56; pulse was 90. She was in deep coma. Pupils

‡Stage 2 was reached two minutes after administration of glutarimide, but the patient slipped back into Stage 3 seven hours later, necessitating a repeat dose with immediate and permanent recovery to Stage 1.

did not react to light and corneal reflexes were absent. There was flaccid paralysis of all extremities. Deep tendon reflexes could not be elicited. She did not respond to painful stimuli. Considered to be in Stage 5 of barbiturate intoxication, she was given 50 milligrams of methylglutarimide* intravenously every five minutes with the addition of 1 cubic centimeter of phenylthiazole† (or 15 milligrams) every other injection. When she had received a total of one full Gram of methylglutarimide* and 75 milligrams of phenylthiazole† one hour and forty minutes later, her pupils reacted to light, her blood pressure rose to 110/80, and deep tendon reflexes were obtainable. She began to move about spontaneously and to weep. She was allowed to remain in this state (Stage 2) for twelve hours. At this time, she was easily aroused to alertness (Stage 1) two minutes after the intravenous injection of 50 milligrams of methylglutarimide.*

Case 3. A 33-year old widow arrived in the hospital in coma. She had been depressed since the death of her husband five weeks previously. She had been receiving an unknown amount of barbiturate drugs for sedation from two physicians during this interval. A few hours prior to admission, the patient's loud snoring disturbed her female companion. When the patient could not be aroused, the family physician was called and the patient was brought to the hospital.

Blood pressure was 115/80; pulse was 100. Respirations were 28 and shallow. The patient was totally unresponsive, exhibiting neither deep tendon reflexes nor any reaction to painful stimuli. The corneal and pupillary reflexes were absent. She was in Stage 5. Two minutes following intravenous administration of 100 milligrams of methylglutarimide,* she tried to open her eyes and groaned. Deep tendon reflexes then returned. Drug therapy was unfortunately discontinued over the next hour. The patient then slipped back into deep coma. Subsequently, methylglutarimide* was resumed in 50 milligram doses every five minutes for the next four hours, for a total of 1100 milligrams. Over the latter two hours, phenylthiazole† was added to the regimen in 15 milligram doses given intravenously, for a total of 120 milligrams. Four hours after initiation of this drug therapy, her condition had stabilized at the Stage 2 level of barbiturate intoxication. Five hours after initiation of this treatment, she had reached Stage 1 and was conversing with her relatives.

Case 4. A 50-year old woman was admitted in a semi-comatose state after having ingested an unknown number of phenobarbital tablets a few hours previously. She had recently been involved in an unhappy love affair. On admission, she was in a stuporous condition, responding incoherently to questions.

Blood pressure, pulse, and respirations were within normal limits. Deep tendon reflexes were sluggish but equal, and both pupils reacted to light. She reacted when stimulated by pinprick and was considered to be in Stage 3 of barbiturate intoxication. Given 50 milligrams of methylglutarimide* intravenously, she promptly sat upright in bed and responded rationally to questions. She remained alert for the remainder of her hospital stay.

Case 5. A three-year old boy underwent cardiac catheterization for a patent ductus arteriosus and received 750 milligrams of rectal thiopental for anesthesia during the procedure. Seven hours later, he was still unresponsive. His pupils did not react to light, the corneal reflexes were absent, and deep tendon reflexes could not be elicited. The child failed to react to painful stimuli, though his blood pressure remained at satisfactory levels. He was considered to be in Stage 4. Methylglutarimide* was instituted in doses of 15 to 30 milligrams intravenously every few minutes. Reflexes returned almost immediately after the institution of therapy. Fifty minutes later, the child was sitting up in bed crying. He had received a total of 225 milligrams during this interval. No relapse occurred after the initial treatment.

DISCUSSION

METHYLGLUTARIMIDE* has been used in England by Shaw, *et al.*[1,2] for cases of barbiturate overdosage, with recovery from the intoxicated state in a matter of minutes. Not all reports have been as favorable as those of Shaw.[4,5,6] Analysis of the unfavorable reports reveals a lack of persistence in those treated with methylglutarimide;* *e.g.*, the interval between doses of the drug ranged from 2 to 24 hours, rather than every few minutes. Also, the occasional patient that slipped back into coma after showing a favorable initial response to therapy was not continued on the drug, but instead, was treated by nonspecific measures.

SUMMARY

1. Eight patients with barbiturate intoxication were treated. Three were managed solely by supportive measures requiring many hours before any marked clinical improvement could be noted. Five were treated with methylglutarimide,* a new barbiturate antagonist drug. Two of these were also given phenylthiazole,† a respiratory center stimulant, which is also a weak barbiturate antagonist. Those treated with methylglutarimide* alone or in combination with phenylthiazole† showed marked clinical improvement within minutes after administration of these drugs. The response to

methylglutarimide* administration may be a useful diagnostic test in cases of coma presenting with a history of possible barbiturate ingestion. No unfavorable side effects were noted among those treated with these drugs.

2. Advantages of reducing the length of barbiturate coma include an abbreviated hospital stay, earlier psychiatric treatment, diminished opportunity to contract urinary or respiratory tract infections, and elimination of prolonged round-the-clock nursing care. Methylglutarimide* and phenylthiazole† appear to be the drugs of choice in the treatment of barbiturate intoxication.

ADDENDUM

Since submission of this manuscript, another patient with barbiturate intoxication was successfully treated with methylglutarimide.* A 50-year old chronic alcoholic was found unconscious on the floor when her husband returned home from work. She had been taking barbiturates for "anxiety" attacks. On arrival at Princeton Hospital, her blood pressure was 100/80. In deep coma, and completely unresponsive, she was suffering from marked respiratory obstruction secondary to trismus and laryngeal spasm. No deep tendon reflexes, pupil or corneal reflexes were obtainable. She was in stage 5 coma.

Therapy consisted of gastric lavage and methylglutarimide* in doses of 50 milligrams intravenously, every 3 to 4 minutes. Thirty minutes after institution of methylglutarimide* therapy, the pupillary and tendon reflexes were obtainable; the respiratory obstruction had cleared; blood pressure rose to 140/80 and the patient was crying and attempting to get out of bed. She was conversing coherently with her husband 2 hours after admission and wanted to go home.

163 Nassau Street

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The Jargon of the Addict

"Cap," "hop," "salt and pepper," have harmless enough meanings in everyday usage but take on a completely different connotation for the drug addict.

"Addicts have a special language as do members of the underworld and others who defy social and legal conventions," according to *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession.

The publication lists some of the most commonly used terms in this special vocabulary as an aid to physicians who may come into contact with an addict. "Cap," for example, means a standard dose and "hop" can be interpreted as either opium or, loosely, narcotics in general. "Salt and pepper," is marihuana or any other essential drug. And "on the nod," as the phrase implies, means sleepy or stuporous from opiates.

Sidney Fink, M.D.

Paterson

The "One Second" Liver Biopsy

Described here is a very swift and valuable diagnostic tool whenever liver biopsy is indicated.

In 1958, Menghini[1] described a blind liver biopsy technic using a thin, aspirating needle.[2] The method is easily mastered and quickly performed. It yields excellent specimens of hepatic tissue. No fatalities occurred in the 1958 report (2000 biopsies); and none have been reported up to this time. Two absolute contra-indications exist: (1) hemorrhagic tendency, (2) suspected hemangioma or hydatid cyst. With the older Vim-Silverman technic (using longer needles) the mortality rate was 0.17 per cent.[3] Obstructive jaundice was a contra-indication to this method.



19-gauge needle above.
Menghini, 1.5 millimeter needle below.

Menghini needles (see the picture) are larger than the standard 19-gauge venipuncture needles. They are, however, made to fit our regular American syringes. During use, a 5-cubic centimeter syringe, containing 3 cubic centimeters of saline solution, is attached to the needle. The saline expels subcutaneous tissue after penetration of the chest wall, and washes the specimen out of the needle bore at the end of the procedure. The syringe also provides suction during the rapid entry and exit from the liver substance. A special baffle in the needle shaft keeps the specimens from entering the syringe, avoiding fragmentation.

In a recent series of 20 cases at Barnert Memorial Hospital, using 1.2 and 1.5 millimeter needles, specimens 15 millimeters long and 1 millimeter in diameter were regularly obtained. The biopsies were done at the bedside, using the suggested intercostal approach. Morbidity was negligible, restricted to occasional mild pain in the right upper quadrant which persisted five to ten minutes.

The Menghini biopsy is of value in medical and medico-legal problems. In our small series it gave rapid answers in jaundiced patients where the differential diagnoses rested between hepatitis and extra-hepatic obstruction, between hepatitis and cirrhosis, and in cases where hemochromatosis, sarcoidosis, toxic hepatitis or hepatic metastases were suspected. Three typical examples are presented.

1. A 65-year old man developed jaundice and anorexia five months after resection of a rectal carcinoma. The diagnosis rested between hepatic metastases or transfusion hepatitis. On the second hospital day, a Menghini biopsy showed acute hepatitis. The family was reassured, and the patient

1. Menghini, G.: *Gastro-Enterology*, 35:190 (August 1958).

2. Available at about $15 the half-dozen from Societa Ico at 6 Piazza Galileo, Bologna, Italy.

3. Mateer, J. G.: Medical Clinics of North America (March 1956) page 444.

subsequently recovered. One year later, he now continues in good health.

2. A 40-year old housewife with gallstones developed jaundice and pain in the right upper quadrant. Blood tests suggested hepatitis. A Menghini biopsy showed cholangiolitic hepatitis. The jaundice cleared on conservative therapy, and a prophylactic cholecystectomy was done six months later. She is now well.

3. A 23-year old industrial worker developed fatigue and anorexia. There was a history of exposure to organic solvents. The Menghini biopsy showed normal hepatic parenchyma. The symptoms cleared on symptomatic therapy. The biopsy report was helpful both medically and legally.

SUMMARY

1. The Menghini technic for liver biopsy is contra-indicated in hemangioma, hydatid cyst or hemorrhagic tendency.

2. Otherwise it is a valuable diagnostic tool, swiftly providing specimens of liver tissue suitable for histologic study. Risk is low and morbidity is slight. It should be considered in any diagnostic problem where hepatic biopsy may afford useful clues.

750 Broadway

Life in the Antarctic

Charles Mullin, M.D., writing in the American Journal of Psychiatry (117:323) points out that food hunger is a greater problem than sex hunger at isolated polar stations. Conditions today are different from what they were at the time of the early explorers. There is little danger or hardship, better communication with the outside world and better selection of personnel. Nevertheless, living for a year in an isolated polar station still makes serious demands on a man's adaptive resources. For eight months of the year there is no communication with the outside world except by radio. For several months there are 24 hours of darkness every day.

Effects of cold are not the most important stresses. The main stresses lie in individual adjustment to the group, the sameness of the surroundings and the absence of accustomed sources of gratification.

Symptoms of hostility are remarkably rare. Related to this phenomenon of controlled aggression is the extraordinary frequency of headaches, which affect the officer and civilian group more than the enlisted contingent. Enlisted men have various ways of expressing their hostile tensions, such as vigorous horseplay and loud complaints.

Sleeplessness is widespread but almost confined to the dark winter season. Explorers are simultaneously exhausted and restless when they try to sleep.

There is a widespread lack of intellectual energy during the winter. Reading is a spare-time occupation, usually more elementary than that characteristic of the individual's customary interests and tastes.

Akin to the intellectual inertia are impaired memory, alertness and concentration, which have some relation to the prolonged exposure to "sameness" — the same limited physical milieu, the same relatively simple routine of life.

Appetite and food consumption are enormous and weight gain is common.

No field of human functioning is more subject to distorted reporting, exaggeration, and repression than sex. *Isolation from women is not a serious problem,* and does not produce any conscious yearning, erotic and otherwise. There is a slight tendency to increased nocturnal emissions and masturbation during periods of inactivity and personal emotional stress.

Most men feel after this period of isolation that something good has happened to them. This is expressed in several ways, for example, more self-discipline and greater adaptability, tolerance, patience and understanding of themselves and other men.

Harry LeFever, M.D.

Jack L. Ward, M.D.

Belle Mead

Recovery from Neurodermatitis of 16 Years' Duration

The skin is a vast sounding board of emotions. While most of us agree with this in theory, it is unusual to offer a case report in which psychiatric care leads to recovery from a skin lesion.

Standing midway between us and our environment, the skin is frequently an accurate barometer of conditions prevailing both within and without. As many cheeks are reddened by embarrassment as by zero temperatures; more "goose bumps" are raised by fright than by frost. Many authors[1,2] have commented on the ability of the skin to express conflicts in the areas of hostility and aggression. This remarkable organ is capable of absorbing enormous quantities of self-directed punishment. The following case report is offered because of the dramatic recovery made by a patient in whom symptoms were unusually chronic and severe.

A 63-year old married white woman was admitted to the Carrier Clinic deeply depressed and agitated, appearing at least 10 years older than her stated age. Cerebration and verbal productions were considerably retarded; suicidal ideation was prominent, although no *conscious* attempt had been made.

Her arms, legs, and to a lesser extent, face and trunk, were marked by innumerable excoriations. The lesions ranged from deep scars to bleeding, freshly scratched areas. Secondary infection was superimposed on several of the lesions. Virtually the entire anterior surface of both forearms and legs were thus involved. The patient's hands were in constant motion: picking, scratching, itching, rubbing. She was unable to abstain from this activity and complained bitterly of itching, which, she said, "I've had forever."

History from the patient's family indicated the continuous presence of the dermatologic manifestations of her illness for 16 years.* During this time pruritis and excoriations had failed to respond to the medicaments (surface and systemic) of over twenty physicians. For many years she had been a "doctor shopper." Ultimately she accepted the condition as incurable.

In the six weeks prior to her admission, the patient's mental status had undergone gradual change with development of a classical picture of agitated depression. She was scratching herself with more vigor than usual. Only after the hints of suicidal threats, was psychiatric attention sought.

Dermatologic consultation shortly afterwards reported "multiple excoriations on arms, forearms, legs and thighs." The dermatologist said: "The eruption is a manifestation of her psychosis. No primary skin eruption can be seen at this time." This condition corresponds to that described as "dry neurodermatitis" by Seitz.[2]

The patient was placed on chlorpromazine 100 milligrams three times a day for agitation. Over four weeks, she received a course of 12 electroconvulsive treatments. Predictably, the depressive symptoms and agitation subsided during this pe-

1. English, O. S. and Finch, S. M.: Introduction to Psychiatry. Ed. 2. New York 1957. Norton.

2. Wittkower, E. D. and Cleghorn, R. A.: Recent Developments in Psychosomatic Medicine. Philadelphia 1953, Lippincott.

*Interestingly enough, the skin condition began when her menses ceased—at age 47. It took only a few months for the skin disorder to reach a full-blown state.

riod. Following her fourth electro-convulsive treatment she said: "My skin has stopped itching." This was followed by gradual clearing and healing of the skin lesions. On discharge, six weeks after admission, she was free from depression and the skin had healed completely, leaving only residual scarification and areas of vitiligo. Pruritus had not re-occurred.

The faces of depression are many.

As we become more aware of the protean manner in which depression may express itself we are recognizing many somatic complaints as "depressive equivalents." As long as the emotional nature of such symptoms is unrecognized their resolution is likely to be unsuccessful.

In retrospect, we view this patient's neurodermatitis as the expression of a long-standing unrecognized depression. Psychic equilibrium was maintained only at the expense of painful, self-destructive picking and plucking. Age, and the vicissitudes of her life had ultimately caused a shift in this delicate balance with rapid decompensation to the severe picture described.

This formulation is supported by her specific response to electro-convulsive therapy. This response has been commented upon by others.[3,4] With the addition of a new group of psychopharmacologic agents classified as "antidepressants" or "mood elevators" (Deprol®, Tofranil®, the MAO inhibitors) we feel that, in chronic neurodermatitis refractory to dermatologic treatment, a trial of one of the antidepressants may be warranted. Psychic evaluation of such cases will be helpful in determining the emotional components. In selected severe cases, consideration should be given to offering an adequate course of electro-convulsive therapy.

The Carrier Clinic

3. Kalinowsky, L. and Hoch, P.: Shock Treatments. New York 1952, Grune and Stratton. Pages 203 and 204.

4. Bauer, A. K. and Perrin, L.: *Diseases of the Nervous System,* 5:180 (1940).

Health Levels and the Population Explosion

In the February 1961 *Progress in Health Services,* George Bugbee expresses optimism about health in an overcrowded world. "Improved health levels in this country" he says have sharply dropped mortality rates and thus led to a population increase. What of the social consequences? Can we cope with the special health problems which the aged must face?

Gains in fighting infectious diseases have centered around the early and middle years. Children do not die in epidemics as they once did. The benefits have been almost as great to persons in the childbearing and chief work years.

Older people have also had years added to their life expectancy. Modern medical care is helping the aged to live more comfortably with their infirmities, and older people are less dependent than formerly. But, the working population is not swamped with older dependents. Although nine per cent of the population is now 65 or over, the per cent is not expected to rise materially in the next 20 years. And when the "dependent" age groups — persons under 18 and those 65 and over — are lumped together, they constitute about the same proportion of the total population as was the case at the beginning of the century.

Recent medical advances rank as one of the major blessings of contemporary life — and as a good reason for being optimistic about the future. Under certain circumstances a rise in health standards can contribute to a population explosion, which means more mouths to feed. But this country has adequate resources to care for a larger population. There is every reason to expect further health progress to result in a more vigorous population, better able to cope with the future.

Thomas K. Rathmell, M.D.

Jorge Mora, M.D.

Floyd Hunter, M.D.

Trenton

Urethane Therapy in Multiple Myeloma*

Potent drugs may cause damage to the liver and other organs through which they must pass. Experiences like this re-emphasize the need for caution.

Hobart Amory Hare, the late professor of therapeutics at the Jefferson Medical College, used to teach that no therapeutic agent would have 100 per cent beneficial effects. The successful practitioner would be the physician who would achieve 75 per cent beneficial results and only 25 per cent undesirable effects. He emphasized that every medical practitioner must recognize that drugs might have undesirable results.

In the years from 1950 to 1960, there have been eleven cases of multiple myeloma at the Mercer Hospital in Trenton. The earliest was a patient of Dr. Hunter's who succumbed to her disease as have all of the other patients, but whose postmortem examination revealed advanced fatty change of the liver.

This was a white woman of 53 admitted to Mercer Hospital in April 1954 with complaints of vomiting and back pain. This had developed five days before admission and was associated with weakness, dizziness, and dull pain in the right upper quadrant and lumbar region. Her past medical history was non-contributory. She had an operation for hemorrhoids as a young girl and had three operations in later years for a recto-vaginal abscess. There had been a recent weight loss of 10 pounds; constipation was noted. Her right upper quadrant discomfort was attributed to cholelithiasis.

Physical examination showed an obese woman with arthritic deformities in the hands. There were no palpable lymph nodes or other viscera. Her complaints were presumed to be due to rheumatic arthritis. Her urine had a specific gravity of 1.007, albumin 100 milligrams, with positive Bence Jones proteins. She had a moderate hemoglobin deficiency. Differential study of white blood cells showed 28 plasma cells. Blood chemistry showed a total protein of 10 Grams with albumin of 2.4 Grams, and 7.6 Grams of globulin. A.G. ratio was 0.316. Sedimentation rate was 36 millimeters in one hour. X-ray of the skull showed classical moth eaten lesions of multiple myeloma. Bone marrow biopsy confirmed this diagnosis. Course in the hospital was rather uneventful.

Therapy started with urethane† 5 grains three times a day. After five days, this was raised to 45 grains (3 Grams) a day. She was discharged on this dosage of urethane. She had received, while in the hospital, a total of 525 grains or 35 Grams. She was not seen again until readmission 4 months later with complaints of burning of the mouth and marked soreness of the tongue. Physical examination now showed an enlarged liver and numerous scattered subcutaneous nodes ranging in size from 3 to 10 millimeters. Blood count showed a hemoglobin of 6 Grams, red blood cells 2.5 million, and white blood cells 17 thousand with 68 per cent plasma cells in the differential count.

The patient died 24 hours after admission. Postmortem examination was done by Dr. Jorge Mora. He noted a bilateral hydrothorax of approximately 500 cubic centimeters. There was a liter of clear fluid in the peritoneal cavity. The subcutaneous nodular masses previously noted presented a pinkish-gray fish-flesh appearance. The outstanding finding was a liver which appeared uniformly enlarged, weighing 2400 Grams. The external surface of the liver presented a reddish-yellow color and was of firm consistency. On section, the lobu-

*From the departments of Pathology and Surgery at the Mercer Hospital in Trenton.

†Also known as urethan, this drug is ethyl carbamate.

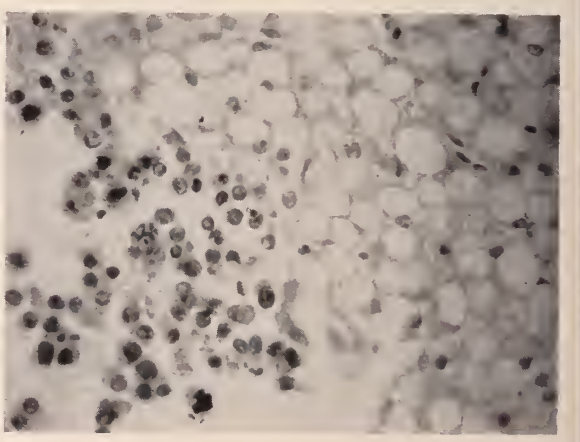
lar markings were outlined by grayish areas resembling leukemia infiltration.

The spleen was enlarged, weighing 590 Grams. There were enlarged lymph nodes in the periaortic area. The lungs showed the usual terminal bronchopneumonic changes. Histologic examination confirmed the presence of extensive plasma cell infiltration of all the viscera with a marked, complete, fatty metamorphosis of the liver and diffuse infiltration of the liver parenchyma with atypical plasmacytes. The bone marrow, on histologic study, showed practically complete replacement by plasma cells and plasmablasts.

Cause of death: Plasma cell leukemia with terminal hepatic insufficiency regarded as secondary to urethane therapy.

We admit the inability to trace the patient's therapy from the time she left the hospital in April through the months of May, June and July. We know that a diagnosis of multiple myeloma had been confirmed and that she was released from the hospital on a daily dosage of 3 Grams of urethane.

Weiss and Santos[1] have indicated that the smallest dose of urethane administered which produced hepatic changes in their cases was 144 Grams. This patient had received 35 Grams in the hospital and was released on 3 Grams a day. Had she continued on this program for 35 days, she would easily have ingested this minimal amount. We regret our inability to obtain better data. Postmortem revealed a liver weighing 2400 Grams, having a greasy-yellow appearance and on section, showing extremely fatty change indicated by the photo-micrograph in the figure. These changes, together with the accompanying plasma cells, causes us to regard this as a complication of urethane therapy. Weiss and Santos[1] say that the site of urethane degradation is presumed to be in the liver with excretion of the resultant products of carbon dioxide, ethanol, and ammonia by way of the lungs and kidneys. Inability to degrade urethane presupposes functional hepatic damage and the studies support the thesis that the liver damage described in human subjects after long time exposure to urethane is due to combined vascular and hepatic cellular toxicity of the drug. They describe, however, liver cell atrophy with dilatation of the sinusoids and destruction of the architecture with swelling and fragmentation in the central veins of the liver lobes associated with severe lobular congestion. The use of urethane (ethyl carbamate) as a therapeutic agent in neoplastic diseases, particularly in the leukemias and related disorders, is well established. It is based upon the capacity of the drug to arrest mitotic activity. It is contended that this drug has specific toxic action on the hematopoietic system, producing anemia, leukopenia, and thrombocytopenia. Cases of hepatic damage associated with the use of urethane have been reported;[2] there is a great possibility that in the present instance, the extreme fatty change noted in this liver may have been either induced or contributed to by the urethane therapy for a disease which in itself is always fatal. Whether the patient was hyper-sensitive to the drug is problematical.



Fatty change of the liver parenchyma with plasma cell infiltration.

We would advocate that all chemo-therapeutic agents be administered on the basis of not what the pharmaceutical houses recommend—but on the basis of what the patient can tolerate, beginning with relatively small doses and gradually increasing the quantity of the drug administered, always under the watchful eye of a cautious physician.

1. Weiss, D. L. and De Los Santos, R.: The American Journal of Medicine, 28:476 (March) 1960.

2. Norcross, John W. and Dean, James E.: The Lahey Clinic Bulletin, 12:27 (July) 1960.

SUMMARY

A PATIENT with multiple myeloma succumbed shortly after having been placed on a daily dosage of 3 Grams of urethane.

Chemo-therapy of any disease process should be based on astute observation of the patient's tolerance to the drug rather than on a publicized pharmaceutical dosage.

The problem of liver disease and its relationship to urethane therapy still remains.

The death of this patient was only a matter of time and the drug administered may have been non-contributory; nevertheless, the liver damage found in this case appears significant.

Mercer Hospital

Leukemia and X-Ray Exposure

W. Court Brown and Richard Doll, in the Proceedings of the (British) Royal Society of Medicine (53:761) point out that opinions differ on the significance of x-ray exposure in utero as a possible factor in leukemia in children. From two investigations (Stewart's and Ford's) it was concluded that the risk of dying from leukemia or other form of cancer before the age of 10 years is *higher if the child has ben exposed to x-rays in utero;* whereas McMahon's investigation did not confirm these findings.

The present survey, from four hospitals in London and four in Edinburgh, showed that of 40,000 children exposed to x-rays in the last two months of intrauterine life, 7 boys and 2 girls died of leukemia. The records for the whole United Kingdom show that the expected deaths from leukemia in this number of children in the general population would be 10.5 (6.1 boys and 4.4 girls).

To study the influence of background radiation on leukemia mortality in the adult population, a standardized mortality ratio was determined for the four principal cities of Scotland, for five rural areas and for the rest of Scotland.

Mortality for leukemia was highest in Aberdeen and in Edinburgh. In Aberdeen this resulted from an excess of acute leukemia and chronic myeloid leukemia, the types that can be produced by ionizing radiations; whereas the excess in Edinburgh was mainly due to chronic lymphatic leukemia. The excess mortality in Edinburgh and Aberdeen can partly be explained by better case-finding, but the possibility remains that an over-average exposure to ionizing radiations contributed to this excess.

Curettage in Skin Cancer

Curettage and electrodesiccation were the method of treatment for 765 epitheliomas of the basal and squamous cell types. For all 765 lesions the cure rate was 98 per cent with the maximum follow-up being 19 years and the minimum being 6 months. In the group followed for 5 years or longer, the cure rate was 97 per cent. Results with squamous cell carcinomas were equal to those obtained with basal cell epitheliomas. Recurrences presented no problem in retreatment. There were no metastases nor deaths. This method has not received proper emphasis in the literature and has been unjustly criticized. Results with curettage and electrodesiccation compare favorably with those obtained by other methods used to treat skin cancer.—J. M. Knox, Arch. Derm., 82:197 (1960).

William O. Wuester, M.D.

Elizabeth

Granulosa-Theca Cell Tumor of the Ovary in a Five-Year Old Child*

An extraordinarily rare case of Granulosa-Theca cell tumor in a child, with resultant premature puberty, is here reported; with good results following surgery.

"The Granulosa-Theca cell tumor "writes Barzilai,[1] "is an ovarian neoplasm of distinctive female germinal tissue type. Its microscopic patterns closely recall those seen in the embryologic and post-fetal forerunners of the Graafian follicle, and in the cyclic phases of the mature stage of this unique formation of the female gonad. This leads to a variety of patterns that, confusing at first glance, nevertheless convey an understanding of their relationship, if the genesis and developmental phases of the Graafian follicle are kept in mind. The Granulosa-Theca cell tumor is physiologically active and has a feminizing influence on the sex characteristics. Clinically, it shows a low-grade malignancy. Although there is no complete agreement as to its histogenesis, there is a tendency to believe this neoplasm originates from remnants of the early mesenchymal core of the ovary."

The development of the tumor from the early mesenchyme of the ovary accounts for its well known variation in microscopic structure reflected by the thecal and granulosal elements. Transition from an epithelial to a sarcomatous pattern in the same tumor is common. This would account for a wide divergence in classification and nomenclature of these tumors which are now considered to have a common origin. Granulosa-Theca cell tumor may have an incidence as high as ten per cent of all ovarian tumors. It is most frequent during active sexual life, less frequent after menopause, and rare in children. Its characteristic physiologic activity is most striking in this young age group. The following case is an illustration of this feature.

A five-year old girl was admitted* December 10, 1960, with a mass in the lower abdomen. About six weeks prior to admission, she was noted to have gradually enlarging breasts. The enlargement increased more rapidly in the last two weeks. On December 3, she had an attack of tonsillitis, and during the pediatrician's examination an enlarged mass in the lower abdomen was discovered. There was no pain associated with either the abdominal mass or the recent enlargement of the breasts.

She was a well developed child in apparent good health. All physical findings were normal except as follows: There is a uniform soft enlargement of both breasts to 3 by 4 by 5 centimeters without pain or nipple discharge. Areola appears normal. Axillae were negative for enlarged nodes. We noticed a visible swelling in the mid-suprapubic region extending almost to the umbilicus, measuring 12 by 12 by 10 centimeters. It is mobile, smooth, symmetrical and it fills the pelvic inlet. One gets the impression that the tumor process is on a long pedicle originating in the pelvis. There is no tenderness. No free fluid is palpable in the abdomen. The spleen, liver, and kidneys are not palpable. There are no other masses or abnormal pulsations palpable. Clitoris is normal, but the pediatric service believes that

*From the Surgical Service of the Wuester Tumor Clinic, Elizabeth General Hospital.

1. Barzilai, L.: Atlas of Ovarian Tumors. Grune and Stratton, N. Y. 1949.

the labia is slightly enlarged. Rectal and bi-manual examination outlines the abdominal mass as separate from a palpable 4 centimeter uterus. Vaginal examination was not done. No pubic hair is present. The general demeanor of this child is more mature than her five years would indicate. In a standing position the body contour shows evidence of early puberty changes. A clinical diagnosis of unilateral Granulosa-Theca cell tumor of the ovary was made and exploration advised.

Chest roentgenogram was negative. Hemoglobin was 10.3, Hematocrit 34; WBC 12,000: Polys 65, Lymphs 31, Juveniles 3, Eosinophiles 1. *Urine*: Specific gravity 1.027, slightly cloudy, acid, negative for sugar, acetone, albumin, microscopic negative.

Surgery: On December 13, 1960, the abdomen was opened through a lower midline incision. An oval tumor of 12 centimeters was lifted out of the pelvis without difficulty due to an elongated pedicle. The mass proved to be the left ovary. The ovarian capsule was tough, intact, and smooth. The uterus was 4 centimeters long and grossly normal. The right ovary and tube were normal. The left tube and ovary were removed by clamp and ligature. Exploration of the abdomen after removal of the mass was negative for evidence of additional tumor deposits or abnormalities. The abdominal wall was closed. The postoperative course was uneventful except for slight vaginal bleeding on the fourth postoperative day. This did not recur. The patient was discharged on the seventh postoperative day.

Pathology review by Dr. Joseph P. Greeley: The specimen consists of a cystic, compressible, ovoid mass, apparently ovary, having a diameter of 13 centimeters. Stretched across the surface is a fallopian tube 55 millimeters long and 6 millimeters in diameter. The fimbriated portion is free. There are two small cystic hydatids of Morgagni. The ovarian surface varies from a yellow to bluish grey in color. Vascular channels are prominent. On section the moderately firm tissue has a pale yellow honeycombed appearance. Some of the cysts contain moderately turbid fluid; other cystic areas exude a mucinous type of fluid.

Sections of ovarian tumor mass show a frequently spindle-shaped cellular stroma; elsewhere the cells are rounded with ovoid slightly spindle nuclei. The nuclear chromatin is fine and cysto-blastic borders are distinct. Occasional cystic areas are surrounded by Granulosa-cells and a clear, watery cytoplasm. Well defined Call-Exner bodies are not noted. In areas the cells show a clear granular background, having the appearance of lutein cells. In still other areas there is hemorrhagic necrosis. *Diagnosis*: Granulosa-Theca cell tumor.

Almost immediately after the operation there was marked regression of the breasts, vulva, and other puberty changes. Within eight weeks regression was judged complete.

The degree of malignancy of these tumors is variable and not determinable on the microscopic picture alone. It is less malignant than ovarian cancer in general. Novak and Browner[2] in a follow-up study on 32 cases report a 28 per cent malignancy rate. "Tumors of immature or malignant character have little or no hormone-producing function."[2] In this child clinical evidence of excess hormone is very apparent. Since the pedicle was long, the capsule thick and intact, and no evidence of infiltration or metastatic deposits was noted, we feel the prognosis should be good. In the absence of gross signs of malignancy only unilateral removal of the pathologic ovary is indicated.

2. Novak, E.: Gynecological and Obstetrical Pathology. Saunders, Philadelphia 1944. Page 356.

815 Salem Avenue

Physicians' Art Exhibit

The 24th Annual Exhibit of the Physicians' Art Association will be held June 26 to June 30 inclusive in New York City. The Committee welcomes paintings, sculptures, photography and craft work by physicians of New Jersey. For entry blanks and other information, write to Dr. Alfred Richman at 307 Second Avenue, New York 3, N. Y.

Jacob L. Drossner, M.D.
Camden

The Incidence of Carcinoma of the Stomach in the Office Practice of Internal Medicine*

Is gastric carcinoma becoming less frequent? Apparently so, according to this survey. Some interesting geographic variations are also reported here.

Twenty-four years ago, when I was graduated from medical school, carcinoma of the stomach was one of the dreaded killers, second, perhaps, only to coronary occlusion. In my medical text of those days, edited by Dr. J. H. Musser,[1] carcinoma of the stomach is quoted as causing 30 to 40 per cent of all cancer deaths. Boyd,[2] in 1932 called it the commonest malignant tumor of the male. As recently as 1951, in the eighth edition of Cecil and Loeb's textbook[3] the authors commented that "cancer of the stomach kills more people than any other cancer of the body" and that the "incidence is increasing."

In the first few years of my practice these predictions were certainly borne out. In the last decade, however, it began to appear that a striking change was developing, and it was for this reason that the following statistical study was undertaken.

The first part of the study is based on the roentgen findings (which, in good hands is reported to be 95 per cent accurate) in a consecutive series of office patients from January 1949 to February 1960, covering an eleven-year span. Our policy was to x-ray everyone with abdominal symptoms promptly, unless they were obviously psychoneurotic; and to x-ray the latter if complaints persisted until the second visit. In all, 363 patients were subjected to a total of 402 roentgen examinations of the upper gastro-intestinal tract. Three certified radiologists did most of the examinations. All but two of the patients were adults, mostly middle-aged, all white, coming largely from middle or upper middle income families. Two-thirds were of Jewish extraction.

TABLE 1.

RESULTS OF UPPER GASTRO-INTESTINAL X-RAY EXAMINATIONS IN 363 PATIENTS

Negative	238
Duodenal ulcer with crater	82
Hiatus hernia	19
Chronic duodenal ulcer	15
Gastric ulcer	11
Irritable duodenum	10
Duodenal diverticulum	7
Ulcer of pyloric canal	4
Carcinoma of stomach	3
Antral gastritis	3
Marginal ulcer	2
Esophageal diverticulum	2
Prolapse of gastric mucosa into duodenum	2
Gastric diverticulum	1
Gastro-enterostomy	1
Postbulbar duodenal ulcer	1
Regional ileitis	1

*Read before Section on Medicine at the 194th Annual Meeting of The Medical Society of New Jersey, on May 17, 1960. From the Department of Medicine of the Cooper Hospital, Camden, N. J.

1. Musser, J. H.: Internal Medicine, 2nd Edition (1934). Lea & Febiger, Philadelphia.
2. Boyd, W.: Textbook of Pathology (1932). Lea & Febiger, Philadelphia.
3. Cecil, R. L. and Loeb, R. F.: Textbook of Medicine 8th Edition (1951). W. B. Saunders, Philadelphia

The findings are listed in order of frequency in Table 1. Carcinoma of the stomach is well down the list. Duodenal lesions far outnumbered the gastric lesions. Eight patients had gastric ulcer, and five of these were women. There were 92 patients with duodenal ulcer, a ratio of almost twelve to one. A fourth of the latter were women.

The carcinomata are listed in Table 2. It will be noted that the last one was seen in December, 1953. Since then, 267 patients underwent 270 upper gastro-intestinal x-ray examinations.

The next question I asked was "how many of the reported benign gastric ulcers were really malignant?" A conservative answer to that question would be "none."

Table 3 lists a follow-up study on all patients with gastric ulcer. All but one of the patients have been followed for at least 5½ years. All are alive. That alone should rule out carcinoma. The single patient with a short follow-up has just had an x-ray showing 95 per cent disappearance of his crater. For five years, not one patient had an x-ray finding suggesting gastric ulcer. Perhaps all gastric lesions are decreasing in frequency.

Four patients had ulcers of the pyloric canal.

TABLE 2.

CARCINOMA CASES

Sex and Age	Diagnosis Confirmed by	Outcome	Date
67-M	X-ray plus operation	Died postoperatively	1953
64-M	X-ray plus operation	No follow-up obtainable	1953
69-F	X-ray	Died 1951	1951

No case of carcinoma of the stomach has been seen in over 6 years. During this time, 267 patients underwent 270 upper G.I. x-ray examinations.

TABLE 3.

FOLLOW-UP OF GASTRIC ULCER PATIENTS

Sex	Duration Follow-Up Years	Original X-Ray Findings	Surgery	Present X-ray Status	Present Status
M	¼	"Benign" ulcer lesser curvature posterior wall	No	95% healed	Alive and asymptomatic
M	5½	Ulcer lesser curvature side of antrum — "Benign"	Subtotal gastrectomy	Negative	Alive and asymptomatic
M	6	Prepyloric ulcer lesser curvature also duodenal ulcer	No	Gastric lesion healed	Alive with periodic symptoms of duodenal ulcer
F	7	Ulcer high on lesser curvature probably benign	Exploratory laparotomy	Not done recently	Alive with some symptoms
F	7½	"Benign" ulcer lesser curvature Pars Media	No	Complete healing	Alive and asymptomatic
M	7½	Prepyloric ulcer probably benign	No	Not done	Alive with some complaints
F	8½	Prepyloric ulcer lesser curvature	No	?	Alive but still has complaints
M	9	"Benign" ulcer lesser curvature	No	?	Alive and asymptomatic

Their follow-up periods were two months, three months, two and one-half years and seven years. All are doing well. This lesion, which rarely proves to be malignant, is more closely related in its behavior to duodenal than to gastric ulcer.

With this suspicion that gastric cancer was becoming infrequent in office practice, I then directed my attention to its incidence in the general hospital population. The records of all patients, ward and private, discharged from the Cooper Hospital (Camden, N. J.) with the diagnosis of carcinoma of the stomach were examined. A comparison was made between 1950 and 1959. Only those cases which met the following criteria were accepted:

1. Where the diagnosis was confirmed by surgical exploration, usually with biopsy of the tumor or of an adjacent node.
2. Where the diagnosis was confirmed at autopsy.
3. Where the x-ray findings were unmistakable and an upper abdominal mass was present. Only four were diagnosed this way, all in the 1950 series. One of the four had a positive cytologic report on ascitic fluid.

In 1950, 24 patients in a total of 15,392 admissions met these criteria. In 1959, only 11 patients in a total of 19,329 admissions were similarly diagnosed. This represents a reduction of 64 per cent. In terms of cases per 10,000 hospital admissions, the incidence dropped from 15½ to 5½ in the brief span of nine years.

Table 4 compares the patients seen in 1950 with those in 1959. This bears out two trends reported in the literature. The first is that carcinoma of the stomach is becoming a disease of older people. In 1950, 25 per cent of the patients were under 50 years of age; the youngest was 26. In 1959 the youngest patient was 55. This disease is also more common in the economic stratum represented by ward patients.

4. Doll, R.: *Gastroenterologia*, 86:320 (1956).
5. Boles, R. S.: *Gastroenterology*, 34:847 (1958).
6. Haenszel, W.: Journal of the National Cancer Institute, 21:213 (1958).
7. Stocks, P.: 33rd Annual Report of the British Empire Cancer Campaign, London (1956).

While the literature does not contain many references to this subject, it has been realized for some time that there has been a worldwide decrease in the incidence of carcinoma of the stomach, particularly in the American white population. Public health statistics are the source for almost all knowledge on this subject. This is the first paper, to my knowledge, which cites the experience of the individual physician.

Doll,[4] in 1956, reported five times as much carcinoma of the stomach in Japan, Finland, and Iceland as in the American white population. Boles[5] points out that from 1950 to 1955 the death rate from cancer of the stomach in the United States declined from 29 to 13 per 100,000. Haenszel,[6] in 1958, stated that the incidence in England and Wales was *not* decreasing, whereas in the United States the incidence had decreased 25 to 35 per cent, especially in younger age groups.

TABLE 4.

CARCINOMATA OF STOMACH
COOPER HOSPITAL

Year	Average Age	Per Cent Male	Per Cent White	Per Cent in Ward Beds
1950	57	70	87	67
1959	66	72	81	64

All agree that there must have been some change in environmental carcinogens, presumably in the type or nature of ingested food and drink. These carcinogens apparently vary with geographic location, perhaps with composition of the soil, as suggested by Stocks.[7] The disease appears to be commoner in northern latitudes. It is also 2½ times commoner among poorer people. This has been reported from England and Norway and the United States. Heredity, in certain areas, may be a factor. Gastric cancer is more common in individuals with blood group A. In the same geographical area, there may be a vast difference in incidence between two racial groups. This has been reported from Hawaii and Java, and it suggests that differences in dietary customs may have something to do with carcinoma of the stomach.

1. Carcinoma of the stomach is becoming less frequent in the United States.

2. The incidence of gastric cancer in the office practice of this writer has been singularly low.

3. As compared to nine years ago the incidence of carcinoma of the stomach at the Cooper Hospital, Camden, N. J., has declined 64 per cent.

1300 Park Boulevard

The Fat American

He may not be ugly, but the average American is dangerously fat or easily capable of being so. According to the Department of Agriculture, U.S. food consumption last year averaged 1,488 pounds per person, which, allowing for the 17 million American who, the President says, go to bed hungry every night, means that certain gluttons on the upper end of the statistical table must somehow down eight pounds or more per day. The Metropolitan Insurance Co. estimates that 48 million Americans are overweight.

These weighty facts are not surprising. The U.S. currently raises 100 million tons of surplus farm produce, and the plain citizen can, with an average of only one-fifth of his income, buy more calories than he can consume. Refrigeration, automated processing and packaging defy season and spoilage. "And," says *Time*,* "in the wake of the new affluence and technics of processing comes a new American interest in how what people eat affects their health."

The public wants to know facts about diet and health, and scientists want to supply them. The man most firmly at grips with the problem is the University of Minnesota's physiologist, Ancel Keys, featured on *Time's* cover for January 13, 1961.

Dr. Keys directs an ambitious, $200,000-a-year experiment on diet, dedicated to the proposition that fat-bred cholesterol is the principal threat to nutritional well-being. Out of cholesterol come Key's main messages:

Americans eat too much. The typical U.S. daily menu contains 3,000 calories, should contain 2,300. (Half the world's population has trouble getting the 1,600 calories a day necessary to sustain life.) Extra weight increases the risk of cancer, diabetes, and cardiovascular disease.

Americans eat too much fat. With meat, milk, butter and ice cream, the calorie-heavy U.S. diet is 40 per cent fat, and most of that is the saturated fat that increases blood cholesterol, damages arteries, and leads to coronary disease.

Cholesterol is a mysterious waxy substance somehow necessary for brain cell formation. It plays a role in the production of adrenal hormones, and is essential to the transport of fats throughout the circulatory system. In the bloodstream, cholesterol is insoluble and cannot be destroyed.

When thus deposited cholesterol is mainly responsible for arterial blockages and thrombi that culminate in heart attacks. Ordinarily, the human liver synthesizes only enough cholesterol to transport fats and to produce bile. But an abundance of fatty foods materially affects the amount of cholesterol in the blood the body can handle.

Thus, says Keys, the big cut in reducing U.S. fat intake should come in popular saturated fats, such as heavily marbled meats and dairy products which promote production of cholesterol in quantities too large for the body to excrete. Substitute instead mono-unsaturated fats (olive oil, most margarines) and polyunsaturated fats (corn, cottonseed, or fish oils) which either have no effect on blood cholesterol levels or actually lower cholesterol content by increasing excretion of bile acids.

The only sure way to control blood cholesterol effectively, says Keys, is to reduce all fat calories in the average diet from 40 to 15 per cent of the total calories. He urges a sterner cut in saturated fats—from 17 to 4 per cent. He warns against confusing blood cholesterol level with cholesterol actually deposited in the arteries. Diet will never remove deposited cholesterol. The object of diets is to keep deposits from growing to the point that they cut off the heart's blood supply.

Key's recommendations are simple: Eat less fat meat, fewer eggs and dairy products. Spend more time on fish, chicken, calves liver, Canadian bacon, Italian food, Chinese food, supplemented by fresh fruits, vegetables and casseroles. "People should know the facts," concludes Keys. "Then if they want to eat themselves to death, let them."

*Time Magazine, January 13, 1961.

Robert R. Smith, M.D.

Summit

The Role of Potassium in Chemically Induced Diuresis*

Potassium, a long neglected electrolyte, is now recognized as one of the essentials of life itself.

Maintaining proper concentrations of potassium in intra- and extra-cellular fluids of the body has long been recognized as one of the essentials for the existence of life. Since the availability of potent, orally effective diuretics and the discovery of aldosterone and aldosterone-blocking agents, potassium has assumed increasing importance. The purpose of this paper is to review some of the physiologic concepts of potassium biochemistry and point out how it is altered by certain disease states and by thiazide-induced diuresis.

BASIC CONCEPTS

Fluid Concentrations—There is a marked dissimilarity between the concentration of potassium in intra-cellular and extra-cellular fluids. In normal individuals, approximately 155 mEq. L. of potassium are present in intra-cellular fluids; but only about 5 mEq./L. in extra-cellular fluids. Concentrations of sodium show the opposite balance: intra-cellular fluids contain only about 12 mEq./L., whereas extra-cellular fluids contain approximately 142 mEq. of sodium per liter. Although potassium accounts for only 5 per cent of the total extra-cellular electrolyte concentration, even small variations can produce profound clinical changes. For example, death may result if the extra-cellular concentration of potassium drops from 5 to 2 mEq./L.

If one compares the great difference in potassium concentration inside and outside the cell, taking into consideration the normal daily intake and output (approximately 50 mEq.) of this electrolyte, it becomes apparent that serum levels do not reflect the large daily turnover of potassium. Hence, it is entirely possible (as in the case of cell dehydration) for normal or elevated serum levels to coexist with signs and symptoms of hypokalemia. The one exception to this is in periodic familial paralysis where potassium shifts from the serum into the cells. Serum levels between 3.5 and 5 mEq./L. are usually indicative of adequate cellular potassium, while low serum levels practically always indicate a deficit.

Intake and Output—Under normal conditions, the amount of potassium in the average daily diet (50 to 100 mEq.) is sufficient to maintain appropriate fluid concentrations and to offset a normal renal output of 50 mEq. Should the diet contain excessive potassium, unused portions are rapidly excreted if renal function is normal. If the diet lacks sufficient amounts, the body continues to lose about 30 mEq. per day, because the kidneys apparently are unable to conserve potassium as rig-

*Presented before the New Jersey Chapter of the American College of Cardiology, Atlantic City, May 17, 1960.

idly as they conserve sodium. The time required for a definite potassium deficiency to develop under these conditions depends on the amount of potassium lacking in the diet. Deficiency occurs more quickly if the sodium intake remains fixed. This is because the body tends to conserve sodium at the expense of potassium.

Changes in Fluid Concentrations—The concentration of potassium in body fluids at any one time depends on the concentrations of other electrolytes, shifts of fluid, the secretion of various adrenal hormones and other factors. In general, however, anything that affects osmolarity (solute concentrations), fluid volume or acid-base balances produces some change in the concentration of potassium. Superimposed on these already complex mechanisms is the ever-present fact that the kidneys are unable to conserve potassium rigidly.

Perhaps one of the best ways to demonstrate how a potassium deficit can develop is by describing the role this electrolyte plays in regulating acid-base balance. If a patient receives large amounts of sodium chloride intravenously (or if he has been receiving fixed amounts of sodium and decreased amounts of potassium) increased amounts of potassium are lost in the urine. To explain this, Berliner and his associates [1] advanced the theory that the renal tubular secretion of potassium takes part in an ion exchange of potassium for filtered sodium ions in the same manner that hydrogen ions replace the sodium ions combined to excretable anions. This results in a competition between potassium ions and hydrogen ions in replacing sodium ions in tubular urine. The predominating ion in this exchange is governed by the quantitative availability of the two ions within the tubular cells. An increase in hydrogen ions in the cells (such as is present in metabolic or respiratory acidosis) allows hydrogen ions to compete most favorably. Hence, sodium ions are reabsorbed in exchange for hydrogen ions, thereby producing a more acid urine. In systemic alkalosis hydrogen ion concentration is low and potassium ions replace sodium ions in the urine, producing a more alkaline urine. Thus chronic alkalosis results in potassium ion depletion.

Excessive serum concentrations of potassium (hyperkalemia) are rare compared to decreased concentrations (hypokalemia), because, as was mentioned previously, potassium excesses are rapidly excreted by the kidney. However, in certain disease-states where urinary volume is greatly decreased (anuria of acute glomerulonephritis, for example), the concentration of serum potassium rises sharply and is often the immediate cause of death.

POTASSIUM CONCENTRATIONS AND DISEASE-STATES

Newman [2] has aptly stated: "Regulation of electrolyte and water balance is the remarkable job of the kidney . . . however, when the kidney is not functioning properly, as in the patient with congestive heart failure, regulation becomes the difficult job of the physician." The kidney adjusts the output of water and most electrolytes separately, so that body composition and volume remain constant despite wide variations in intake. To do this, the kidney relies on specific hormonal stimuli and on changes in the renal blood flow and glomerular filtration rate, renal venous pressure, oxygen tension, acid-base loads and mechanical intra-abdominal pressure. It follows, therefore, that disorders which drastically increase or decrease any of these regulatory factors also reduce the efficiency of the kidney and fluid concentrations of potassium. The effect of several important disease-states on the excretion and/or retention of potassium is discussed below.

Cardiovascular Disease—Since its recent discovery, aldosterone, an electrolyte regulating hormone secreted by the adrenal cortex, has become an important factor in cardiovascular disease. When it is secreted in excess, aldo-

1. Berliner, R. W., Kennedy, T. J., Jr. and Hilton, J. G.: Am. J. Physiol., 162:348 (1950).
2. Newman, E. V.: Journal of the American Medical Association, 116:2046 (1960).

sterone causes sodium retention and a concomitant loss of potassium. In relation to cardiovascular disease, aldosteronism is usually secondary rather than primary, hence it is not a result of adrenal malfunction.

In normotensive and mildly hypertensive patients, Laragh[3] reported that aldosterone levels are rarely elevated. However, he found that the level of this hormone was abnormally high in about 50 per cent of patients with moderate to severe hypertension and in virtually all patients with severe and malignant hypertension. In the latter group, some levels were greater than those ordinarily observed in patients with demonstrated primary aldosteronism. Because of the sodium-sparing, potassium-wasting action of aldosterone, Meneely[4] has suggested that, to prevent patients from developing hypokalemia, the basic consideration in antihypertensive therapy should concern restricting sodium chloride intake (or enhancing its excretion by artificial means) and increasing potassium intake.

Increased aldosterone levels are often found in patients with congestive failure and, if potassium intake is inadequate, can result in an abnormal negative balance of potassium and a concomitant retention of sodium. Some of the deleterious consequences of potassium loss in these patients include: (1) a weakened action of the myocardium; (2) a decrease in the effectiveness of digitalis due to the potentiation of its toxic effects; (3) the precipitation of a nephropathy characterized by proteinuria, inability to produce a concentrated urine, and a rising azotemia due to overall renal insufficiency.† Objective and subjective manifestations of potassium deficiency usually are not observed until the serum level falls to 3.5 mEq./L., or lower. Weaver and Burchell[5] have observed that electrocardiographic changes due to hypokalemia occur with regularity when serum potassium levels are less than 3.3 mEq./L. Changes have been seen at this level and above it, but not with any degree of regularity.

Hepatic Disease—Cirrhosis of the liver, in common with the nephrotic syndrome and congestive heart failure, is often complicated by abnormal retention of sodium and water. The body tends to conserve sodium at the expense of potassium. As has been shown by Chart and Shipley,[6] aldosterone secretion is increased in cirrhotics. Thus, the possibility of potassium deficiency in these patients is an important consideration. For example, Walker, *et al.*[7] found that the sodium potassium ratio in the urine of cirrhotics is usually much lower than that in the urine of patients with congestive failure. The effects of potassium deficiency in cirrhotics are similar to those already discussed. The incidence of hypokalemia in cirrhotics is generally high, increasing with the severity of the disease, because it is difficult for these patients to maintain adequate serum levels, even if they are receiving relatively large amounts of supplemental potassium.

Renal Disease—Despite the singularly important task the kidney has of adjusting the concentration of electrolytes, the extracellular fluid volume and the acid-base balance, information about renal factors influencing the excretion of potassium is not complete. Since the primary excretory route of potassium is by way of the kidney and since the most important renal factor controlling the final composition of urine appears to be a "proper balance" between glomerular filtration and tubular reabsorption, any factor that tends to upset this balance would also cause a derangement in the excretion of potassium. The factors most likely to affect glomerular filtration are renal blood flow and the solute concentration of the blood, while the most prominent one affecting tubular reabsorption involve the secretion of hormones (aldosterone par-

†In addition, a cellular deficiency of potassium has been known to aggravate disturbances in heart rhythm associated with coronary artery insufficiency.

3. Laragh, J. H.: Aldosterone Secretion in Benign and Malignant Hypertension. Presented at Am. College Physicians Annual Meeting, 1960.

4. Meneely, G. R.: Electrolytes in the Treatment of Hypertension. Saunders, Philadelphia, 1959. Page 509.

5. Weaver, W. F. and Burchell, H. B.: Circulation, 21:505 (1960).

6. Chart, J. J. and Shipley, E. S.: Journal Clin. Invest., 32:560 (1953).

7. Walker, W. G., *et al.*: Journal Chronic Dis., 10:47 (1959).

ticularly), ion exchange, and excretion and reabsorption of individual ions and other solutes. With regard to the loss of potassium, a large proportion of this electrolyte is reabsorbed by the proximal tubules, and most of it that appears in the urine is excreted by the distal tubules. Hence, the excretion of potassium by the tubule is largely dependent on the state of acid-balance existing with the tubule cells (see example given under *Changes in Fluid Concentrations.)*

In chronic nephritis, the inability of the kidney to produce a concentrated urine leads to a large volume of dilute urine and increases the possibility of renal acidosis. As acidosis progresses, the tubular reabsorption of organic acids and other wastes results in a loss of fixed base, including potassium. In acute glomerulonephritis, potassium losses occur as a result of excessive protein catabolism. Increased levels of aldosterone have been found in the urine of patients in the nephrotic stage (nephrotic syndrome) of glomerulonephritis and is believed responsible, to some extent, for stimulating the kidney to retain sodium and increase its excretion of potassium.

POTASSIUM AND THIAZIDE INDUCED DIURESIS

For all practical purposes, the principal action of the thiazides is limited to the kidney and involves (through the inhibition of tubular reabsorption) an increased excretion of sodium, chloride, water, bicarbonate and potassium. The most profound inhibitory effect is on sodium and chloride; potassium and bicarbonate are affected to a lesser extent.

Thiazides are believed to increase the potassium excretion through two principal mechanisms. Neither of these is completely understood. Other mechanisms are probably also involved. The first mechanism involves the intimate relationship between the excretion of sodium and potassium. According to Berliner,[8] there is no evidence that diuretics increase the excretion of potassium by interfering with its reabsorption. Most of the potassium that appears in the urine is excreted by the distal tubules through an exchange of potassium ions for sodium ions, and the rate of this exchange is governed by the amount of sodium made available to the exchange mechanism. Hence, since the primary renotropic effect of the thiazides is the inhibition of tubular reabsorption of sodium, greater amounts of this electrolyte become available for exchange with potassium, the overall effect being an increased kaluresis. The second mechanism concerns the interplay between the thiazides and adrenocorticoids, particularly aldosterone. The administration of these compounds causes sodium retention and increases potassium excretion. The co-administration of a thiazide reverses the sodium retention induced by the steroid, but further increases potassium excretion. Therefore, in patients with increased levels of aldosterone, or in those receiving other adrenal steroids, an already increased potassium excretion may be further increased by the concomitant administration of a thiazide. The importance of these effects can be seen from the statement of Falls and Ford,[9] "This kaluresis may be the basis for many of the side reactions that have occurred with thiazides and have limited their use in a number of situations."

How frequently does excessive potassium depletion occur during treatment with a thiazide? Gifford[10] observed that 40 per cent of patients receiving chlorothiazide exhibited serum potassium levels less than 3.5 mEq./L., and that in 12 per cent of the patients, levels were decreased to less than 3.0 mEq./L. Generally, symptoms of hypokalemia were rare, but the rapidity with which symptomatic hypokalemia developed in several patients, especially when they became acutely ill or during a postoperative period, led to the speculation that total body stores of potassium may be depleted to a greater extent than serum values would indicate. Gifford[10] demonstrated that patients who are receiving digitalis in addition

8. Berliner, R. W.: Annals of the New York Acad. Sci., 71:324 (1958).

9. Falls, N. E. and Ford, R. V.: New England Journal of Medicine, 263:296 (1960).

10. Gifford, R. W.: Hahnemann Symposium on Hypertension, Saunders, Philadelphia, 1959. Page 564.

to chlorothiazide should be given supplements of potassium routinely, because hypokalemia aggravates digitalis intoxication. Hollander, *et al.*[11] have reported that thiazide compounds lowered serum potassium by more than 0.4 mEq. L. in 40 per cent of his patients, and to below 3.5 mEq./L. in 24 per cent. Hypokalemia was less prevalent when a thiazide was administered [11] in the lowest effective dose and when it was given with a diet that contained adequate amounts of sodium and high amounts of potassium. According to Sackner, Wallace and Bellet [12] the most important untoward effect of hydrochlorothiazide was the development of hypokalemia which they observed in 15 per cent of their patients. Where the reduction of plasma potassium was associated with impending hepatic coma in cirrhotics, withdrawal of the drug and administration of potassium relieved the symptoms of hypokalemia. They also reported on one patient who did not respond to thiazide therapy until supplemental potassium was added to the regimen. Friend [13] has also observed this latter effect and has demonstrated that other side effects of thiazide therapy such as hyperuricemia and abnormal carbohydrate metabolism are usually present when serum potassium levels have become abnormally low.

It is thus evident that a thiazide diuretic decreases, to some degree, the serum potassium level of a considerable number of patients. The next questions are: (1) which patients should receive supplemental potassium? (2) How much potassium is required daily to avert hypokalemia?

Some observers recommend that potassium supplements be used in virtually all patients; others feel that only certain patients (see below) should receive them, while still others believe that such supplements provide a false sense of security and that a more rational approach would be to adjust the diet or size and frequency of the dosage of the thiazide in order to arrive at a "happy combination." According to Friend,[13] depression of serum potassium occurs in most patients who are treated with a thiazide over prolonged periods of time. He recommends that these patients should receive two to four Grams of potassium chloride daily if the serum level is below 3.5 mEq./L. Magid and Forsham [14] agree with Friend about the type of patient who should be given supplemental potassium, but suggest that *all* patients receiving long-term therapy be given one to three Grams of potassium chloride daily as a prophylactic measure. In general, supplemental potassium should be considered in most patients except those with renal insufficiency. It should be a paramount consideration in any patient who, because of intensive or prolonged diuresis, a restricted sodium chloride intake, concomitant corticosteroid therapy, and/or pre-existing renal or liver disease, may be disposed to excessive potassium losses. Supplementation should also be considered in patients in whom even a moderate hypokalemia may be hazardous, e.g., in patients with hepatic cirrhosis or in patients subject to cardiac arrhythmias due to digitalis intoxication and/or coronary artery disease. Most investigators say that a daily dose of between two and four Grams of potassium chloride (40 to 80 mEq.) is necessary to prevent hypokalemia.

Several preparations are available which contain hydrochlorothiazide and potassium chloride. The two products most familiar to me, however, contain relatively small amounts (approximately 6 mEq.) of potassium ion and, for this reason, are of limited use, particularly in patients requiring the usually recommended supplementary dose of 2 to 4 Grams. There is a preparation available for clinical trial which contains, in a sodium and sugar-free, effervescent tablet, 25 milligrams of hydrochlorothiazide and 20 mEq. of po-

11. Hollander, W., Chobanian, A. V. and Wilkens, R. W.: Hahnemann Symposium on Hypertension, Saunders, Philadelphia, 1959. Page 575.

12. Bellet, S., *et al.*: American Journal Med. Sci. 74:582 (1959).

13. Friend, D. G.: Clinical Pharmacology and Therapeutics 1:5 (April 1960).

14. Magid, G. J. and Forsham, P. H.: Clinical Pharmacology and Therapeutics, 1:606 (May 1960).

tassium as the bicarbonate. Based on the literature supplied by its manufacturer,† this preparation appears to reduce the incidence of excessive potassium depletion. For example, of the 185 patients on whom serum potassium levels were measured before and following treatment (average duration: 3.6 weeks), only 18 experienced a decrease of greater than 0.5 mEq./L.; half of the decreases were between 0.6 and 1.0 mEq./L. Moreover, only 12 of the 185 patients had final serum levels of 3.5 mEq./L. or less. Since 7 of these 12 patients had initial levels that were 3.5 mEq./L. or less, it would appear that the preparation reduced the incidence of excessive potassium depletion (generally reported as being anywhere from 15 to 40 per cent of the patients treated) to only 3 per cent. If reports on this product continue along the same lines, it would appear to be the drug of choice in patients requiring a thiazide, because it would also provide an improved margin of safety against the development of hypokalemia.

†Warner-Chilcott, Morris Plains, New Jersey.

34 Sheffield Road

The Weaker Sex Lives Longer

Why is it that American women appear to be more sickly than men (and women lose more time through illness) but, in general, outlive men?

Dr. Lawrence E. Hinkle, Jr., suggests that one reason is the culturally determined differences in the attitudes towards what constitutes illness and what creates an *acceptable reason* for disability in men and women.

In spite of statistics showing that American women have more illness than American men, there has been a reluctance to accept this because the death rate for American men is higher at all ages and their life expectancy less. To clarify this problem, the following study was carried out:

One hundred and sixteen men and 96 women (comparable in age, ethnic and social background, occupation, social and economic position, exposure to infection and trauma, place of domicile and method of observation) were studied over a 25-year period with regard to the nature and duration of every episode of disabling illness that occurred among them.

The incidence of disabling illness among the women was significantly higher than among the men. However, the difference in incidence was almost entirely accounted for by a higher incidence of colds, "grippe," pharyngitis, acute gastroenteritis, dysmenorrhea, muscular pains, minor cuts and bruises, headaches, and minor periods of tension, anxiety, asthenia, or depression.

The women were disabled more frequently and for a greater proportion of the time than the men. But the incidence of serious, life-endangering illnesses was somewhat higher among the men. An analysis of the risk of death among the two groups (based upon expected case fatality rates of the illnesses experienced) led to an estimate that, over a 20-year period, the men experienced a risk of death from illness greater than that of the women, in a ratio of 4 to 3.

The higher incidence of illness reported by the women, the greater amount of disability that they experienced, and the greater number of visits that they made to the doctor, were largely the result of culturally determined differences toward what constitutes illness and what creates an acceptable reason for disability in men and in women.

—From a paper by L. E. Hinkle, Jr., read April 12, 1961 to the Greater New York Safety Council.

Trustees' Meeting: March 19, 1961

The Board of Trustees met in Trenton on Sunday morning, March 19, 1961. Among actions taken were the following:

At the February meeting, the Board had authorized Dr. Buchanan, President-Elect, to attend the AMA Conference on Legislation. It was left to the discretion of the President to appoint two other members, not of this Board. Dr. Madara, a member of the Council on Legislation, was appointed and is attending the conference. The vice-chairman of the council, Dr. Campo, was unable to accept the assignment.

CONFERENCE ON VOLUNTARY HEALTH INSURANCE

Invitation was received to send representatives to the regional conference in Washington, D. C., on March 26, 1961. Dr. Lloyd was asked to attend as the Society's representative. Medical Surgical Plan is also sending two representatives: Dr. Comando and Mr. Zotti.

Action: Dr. Lloyd's expenses in connection with attendance at the Conference will be paid by the Society. The President's actions were approved.

CRIPPLED CHILDREN'S COMMISSION

On June 30, 1961, Dr. Frederick G. Dilger's term as a member of the New Jersey State Crippled Children's Commission will expire.

Action: The Board recommends the reappointment of Dr. Dilger to the Commission.

CHIROPODY SCHOOL INSPECTION

At the February meeting, the Board had authorized the President to appoint three members of the Society to inspect the Ohio College of Chiropody, with representatives of the State Board of Medical Examiners.

Action: The following appointments were approved: Dr. C. Byron Blaisdell, Dr. James H. Spencer, and Dr. Edwin J. Otis.

CONFERENCE WITH CIO

On March 2, 1961, the Executive Committee met with representatives of the New Jersey CIO "to discuss areas of common interest relating to medical care." This had been requested by the CIO. The meeting developed along the lines expected—request for a compromise on the part of the Society with regard to A-197. No compromise was made.

This meeting was followed by a radio discussion, under the auspices of the Rutgers University Radio Forum, between Dr. McCall and Mrs. O'Flaherty, assistant to the president of CIO. At this discussion, the positions of The Medical Society of New Jersey and the CIO concerning A-197 were developed and defended.

Dr. Bowers emphasized the desirability for maintaining an open door for further meetings with representatives of labor, and urged that every opportunity should be afforded labor to meet with medicine and talk over common problems.

Action: The report was accepted.

MEDICAL-DENTAL LIAISON COMMITTEE

As directed by the Board, at its January meeting the Medical-Dental Liaison Committee met on February 23, 1961, to explain to the dentists why their proposed amendment to the medical service corporation act embraced "far more than that contained in the original agreement." They agreed that their version did not successfully limit eligible compensable services under MSP to dental-oral surgeons operating in hospitals in New Jersey. Agreement was reached to achieve this satisfactory limitation by inserting the phrase "in an approved hospital" after the phrase "rendered such persons." The agreed upon amended version reads:

Notwithstanding any other provision of the act to which this act is a supplement, benefits shall not be denied to an eligible individual for eligible services when such services are performed or rendered such persons in an approved hospital by a licensed dentist within the scope of his practice. The practice of dentistry shall be deemed to be within the provisions of the act to which this act is a supplement and licensed dentists shall have the privileges and benefits in the scope of their practice under such act as are afforded thereunder to licensed physicians and surgeons in the scope of their practice.

Question arose as to why "eligible services" were not designated as "dental-oral surgery." Dr. McCall and Mr. Nevin explained that MSP has the right to control eligible services and the specific designation is not required.

Action: This portion of the committee report was accepted as presented.

Dr. McCall reported that the members of the liaison committee had agreed that it would be desirable to maintain more constant and effective liaison. It was suggested:

1. That each year the Society sponsor a general meeting of all its liaison committees—perhaps in late February or early March when the legislative positions for the Society for the new year have been arrived at. Purpose of this annual meeting would be to retain contact with all the professions with which liaison exists and to encourage them severally to call for meetings when such meetings are viewed as desirable or necessary.
2. That the executive secretaries of those professional groups concerned with health services (medicine, nursing, pharmaceutical, dental, and hospital) meet for luncheon and informal discussion about every six weeks. The members of the liaison committee approved this suggestion and agreed to support it.

Action: These two suggestions were approved in principle.

MSP PUBLIC RELATIONS COUNSEL

A communication from MSP reported that at its February session, the Board authorized the appointment of a qualified individual whose salary will be paid entirely by MSP, who will be responsible to the Executive Vice-President and whose efforts in the field of education and information will be coordinated with the existing Public Relations Department.

Dr. McCall and Mr. Nevin replied to several questions raised. The word "coordinated" as used in the Plan Board's action means "processed through." The new employee will not have the title of "public relations counsel" because it would conflict with the Joint Operating Agreement which provides that there shall be only one public relations counsel for both Plans. However, the new employee will function in this capacity under a title to be selected. He will be paid by MSP outside the current division of public relations costs. They agreed that the Plan's action was a compromise, but it is a step which can be taken immediately without interfering with the Joint Operating Agreement. Potential achievements of this appointment will be the disassociation of identities of Blue Cross and Blue Shield and the elimination or reduction of the public's confusion about the two Plans, and development of sympathetic understanding of the sound character and purpose of the Plan, of its economy and low cost, and of the physicians' part in creating and maintaining it.

Action: The Board recorded its approval of this arrangement as potentially adequate; but reserved the right, after a proper interval, to review the entire operation and then to make such further recommendations as it deems desirable. This Board is further memorialized to reconsider this problem annually at the time that the nominations for the Plan Board of Trustees are considered; and at the expiration of the "proper interval" proceed to weigh the adequacy of this new arrangement.

UNEXPIRED TERM OF CARL K. WITHERS

The Plan Board approved the nomination of Gustave E. Wiedenmayer as a member of the corporation and of the Board of Trustees of Medical-Surgical Plan of New Jersey to serve until the next annual meeting of the corporation and until his successor qualifies, subject to the approval of the nomination of that successor by The Medical Society of New Jersey.

Action: This nomination was approved.

CONTACT LENSES

In a letter from the State Board of Medical Examiners, it was reported that the Attorney General has under study the question whether the fitting of contact lenses is permissible by optometrists, opticians, ophthalmic technicians or anyone other than a medical doctor. The Attorney General is desirous of obtaining the opinions of all interested parties. He has asked The Medical Society of New Jersey to express its opinion.

This request was discussed at the meeting of the Special Committee on the Conservation of Vision on March 5, 1961. The committee agreed that the prescribing and fitting of contact lenses is a medical service. The committee submits the following supporting data:

The indiscriminate prescription and application of the contact lens is not in the best interest of the public health. A contact lens study made in 1960 in New Jersey showed that the contact lens is not an innocuous prosthesis. The study indicated that severe ocular damage, loss of vision, and even loss of the eye can result from improper use of contact lenses. (This report was sent to the Attorney General on May 28, 1960).

In view of these findings, the decision to prescribe and use contact lenses should not be made lightly and without need. The proper practice of prescribing contact lenses requires careful evaluation, based upon medical history, medical examination, and medical diagnostic procedures. This constitutes the practice of medicine. *Reference*: "Special Report on Use and Application of Contact Lenses" prepared by the Special Committee on the Conservation of Vision of The Medical Society of New Jersey. This report is replete with medical diagnostic procedures which constitute the practice of fitting contact lenses—particularly on page 2, items (d), (g), and especially (h), which are definitely medical practice acts, involving medical diagnosis and medical treatment:

(d) Use of the drug, fluorescein, for observation of the variations in the distributions of the fluid between lens and cornea.

(g) Slit lamp biomicroscopy of the cornea to diagnose the presence or absence of pathologic change in corneal epithelium or corneal stroma (1) without fluorescein and (2) with fluorescein. Slit lamp biomicroscopy is a major subject in postgraduate medical education in ophthalmology. Its prerequisites are anatomy and histology.

(h) Treatment of pathological changes, if any.

It is probable that every wearer of contact lenses at some time will either injure, irritate, or inflame the eye as a result of wearing the contact lens. Prompt diagnosis by medical examination, followed by medical treatment and the use of drugs becomes a necessity in the prevention of ocular damage. Such services can be rendered only by the medical profession.

There is nothing in the revised Optometric Act of September 1955 to indicate an intent to allow optometrists to prescribe the use of contact lenses, although contact lenses were in common use prior to this time.

The only reference to contact lenses in the optometric act is in the paragraph "Revocation of Certificates . . . Unprofessional Conduct," wherein it states they are prohibited from . . . "Advertising to perform optometric services, or with reference to *providing* glasses, spectacles, contact lenses, etc., free of charge or on credit, etc." The word *providing* certainly cannot be construed to mean the practice of prescribing and fitting contact lenses, which as already stated is a medical act. As a matter of fact this reference occurs in a paragraph stating they are "prohibited" from . . .

Action: The above statement is approved as representing the position of The Medical Society of New Jersey. This report, together with a copy of the May 28 letter and a copy of the Special Report on "Use and Application of Contact Lenses" will be forwarded to the Attorney General; and a copy of this material will be sent to the State Board of Medical Examiners.

RELATIONSHIP BETWEEN M.D.S AND D.O.S

Received and noted was a reply from the AMA to the Board's request for official information concerning the action and decision of the Judicial Council with reference to the matter involved in Resolution No. 23:

"To sum up, there has been no change in AMA policy: All voluntary professional associations between doctors of medicine and osteopaths are unethical. The action of the Joint Commission on Accreditation of Hospitals does not amend or rescind the action of the AMA House of Delegates."

MSP FEE SETTING

The Board received and noted a resolution from the Mercer County Medical Society which recorded that society's opposition to any bill or amendment which would give the Commissioner of Banking and Insurance the authority to establish the fees, either in the aggregate or individually, for Medical-Surgical Plan or any substitute for such plan; and which urged the members of that society to participate only in the Medical-Surgical Plan of New Jersey as it is now constituted.

STATE ALCOHOLISM PROGRAM

From Commissioner Tramburg of the State Department of Institutions and Agencies, the Society has received a copy of the State Program for the Care of Alcoholics. The Commissioner stated that ways of improving facilities have been under study for some months. Specific recommendations for a broader program will be forthcoming in the immediate future. New proposals will make specific provision for much more active participation of

medical practitioners in the overall planning and supervision of departmental activities.

CONFERENCE OF PRESIDENTS

Notice was received that the 1961 Conference of Presidents will meet in New York City on June 25, during the AMA annual meeting. In accordance with the Conference bylaws and the number of members in The Medical Society of New Jersey, 1961 Conference dues are $75.00.

Action: The 1961 Conference dues will be paid.

Medicare

Identification of Dependents of Servicemen

Here is a recent release of the New Jersey Hospital Association:

From time to time, service dependents have presented DD Form 1173 (Uniformed Services Identification and Privileges Card) bearing the word 'indefinite' in lieu of a specific expiration date, and have said that such cards are issued to dependents of career servicemen. However, we have been advised by higher military authority that:

> All Service Regulations require a definite expiration date on DD Form 1173. Early in the program, the Air Force permitted indefinite expiration. This was changed several years ago and new cards issued. In all instances of this nature, except as noted above, an officer or other individual at the local level through a misunderstanding issued cards with an indefinite date.

The above clearly indicates that DD Form 1173 with an indefinite expiration date has been issued in error, and is *not acceptable*. On occasion, service dependents assert that they are eligible for Medicare benefits after the expiration date on the DD Form 1173 because the service member is entitled to terminal leave or is allowed credit for travel time between the Separation Center and his home. Hospitals should *not* accept such persons *as Medicare patients*, even 'emergency' cases, unless they can produce a letter from an official authorized to issue the DD Form, or a copy of discharge papers, which clearly indicates an extension of eligibility beyond the date on the expired DD Form 1173. Actually eligible dependents are entitled to care authorized under the Program from 12:01 a.m. on the day the active service begins up to 11:59 p.m. on the day such active service terminates. Service members *known* to be 'deserters,' or on a Temporary Disability Retirement List, are considered to be on *inactive duty*, and their dependents are *not* entitled to care at government expense.

The ODMC is anxious to learn of problems arising out of the failure of the Uniformed Services to comply with Medicare regulations governing the provision of authorized care by qualified civilian sources, so that remedial action can be initiated. However, the ODMC cannot resolve credit or administrative problems which arise when the dependent fails to produce the required or acceptable forms of identification, or when the hospital submits a claim which is not complete from the standpoint of the identification data required.

It is the hospital's responsibility to exercise "due care" in examining DD Form 1173 or other acceptable forms of identification prior to accepting the dependent as one entitled to Medicare benefits. It is the hospital's prerogative to refuse to accept a Medicare patient if the dependent does not present identification which meets the criteria outlined in the Hospital Manual.

To be payable, a Medicare claim must meet certain criteria. If a hospital is unable to submit a complete and otherwise acceptable DA Form 1863, it should not expect to be reimbursed by the government: payment for the care rendered becomes a private matter between hospital and patient.

By substituting *physician* for "hospital" the above applies also to physicians.

Annual Report of the Passaic County Medical Society*

F. Albert Graeter, M.D., President, Passaic

During the past year our Passaic County Medical Society has tried to be of as much help to its members as possible. It has tried to improve the doctor-patient relationship, and also has tried to give increased health services to the residents of our county.

We were in the forefront in urging the City of Paterson to appoint a qualified physician to the office of Health Officer.

Our annual press dinner was well attended by the three daily papers of the County, and we believe we enjoy better or as good press relations in this county as any other society in the state.

Most of our members have transferred their malpractice insurance coverage to the American Mutual Liability Insurance Company. We have also appointed a Loss Control Committee to meet with their legal department whenever any suits may be instituted. The American Mutual Liability Insurance Company has promised to be guided by our Committee's recommendations in deciding upon whether to contest or to settle such suits.

At our December 1960 session, the members recommended that we support the Relative Value Index that will be proposed to The Medical Society of New Jersey.

Your society has adopted the following resolutions to be presented to the 1961 House of Delegates of The Medical Society of New Jersey.

1. Resolution requesting the State Society and the A.M.A. to evaluate and give leadership to the anti-influenza campaign similar to the campaign against poliomyelitis.
2. Resolution binding State Society delegates to the A.M.A. to vote for Social Security coverage at A.M.A. meetings.

A donation of $1,000 was given to the Passaic County Homemaker's Service to help them meet rising costs in the fine work they are doing.

Our Public Relations Committee under Dr. David Levine, has been very active this year. The following actions have been taken.

1. 100,000 Emergency Medical Stickers were distributed to doctors and the public through bank statements, the Passaic County Pharmaceutical Association and directly from the medical society office.
2. 10,000 Personal Health Information cards were sent to members for distribution to their patients.
3. An Indoctrination Program was set up for orienting new members. At a well attended breakfast, the economic and ethical problems concerning the practice of medicine were discussed. It is planned to hold this indoctrination meeting biannually. A brochure will be sent to new members on this subject.

I believe more interest and better attendance was shown at our monthly meetings than ever before. This was wholly due to our vigorous chairman, Dr. Edward A. Wolfson. As usual, the meetings sponsored by the County Heart Association, Valley View Hospital and Passaic General Hospital were outstanding. The rest of our meetings consisted of a joint meeting with the Passaic County Bar Association on medico-legal relations, a meeting in which our Congressional candidates for Congress gave their views on medical legislation; a pro and con meeting on the advantages of oral vs. parenteral polio immunization and one on the financial aspects of investments for doctors.

I want to thank the Woman's Auxiliary for their fine support and also Mr. Norris, our Public Relations Counsel, Mr. Klughaupt, our Legal Counsel, and our very efficient Executive Secretary, Mrs. Katherine Cingale. My thanks go to all our Committee Chairmen and their committees who have contributed of their time for the benefit of our Society.

*Received after closing date for the April issue.

Obituaries • • •

DR. WILLIAM J. BROWNING, SR.

Dr. William J. Browning, Sr., died on April 15 at the Cooper Hospital. Born in 1901, Dr. Browning was graduated in 1929 from the Jefferson Medical College. After interning in Camden, he settled in Merchantville, where he served the people of that area for more than a quarter of a century. Dr. Browning, a family doctor of the old school, was affiliated with the medical service of Cooper Hospital. He was active in the affairs of the Camden County Medical Society.

DR. CHARLES H. FINKE, SR.

At the grand old age of 89, Dr. Charles Henry Finke, Sr., one of the leaders of the profession, died on April 23. Born in Hoboken, Dr. Finke received his M.D. in 1898 from Bellevue. The following year, he entered general practice in Jersey City, and in 1905 was named Health Commissioner of that municipality. The following year, he was the leader of a group of physicians and prominent laymen in organizing and founding the Greenville Hospital, and for a quarter of a century, Dr. Finke served as President of the Board of that hospital. He became increasingly interested in pediatrics and served for some time as chief of one of the pediatric services at the Jersey City Medical Center. Dr. Finke was a charter member of the American Academy of General Practice. He was active in the affairs of the Hudson County Medical Society, having for several terms served as its secretary. In 1948 he was a gold star laureate of The Medical Society of New Jersey.

DR. WERNER KORNFELD

On April 4, death came to Dr. Werner Kornfeld, a pediatrician active in the field of child development. Born in Vienna in 1892, he was an honor graduate of the medical school of the University there in the class of 1924. By that time he had acquired a Ph.D. in biology and a reputation in cultural and physical anthropology. On being graduated from the University, he became deputy to Dr. Clement von Pierquet and embarked on research in child development. In 1938 he came to the United States, setting up an office in East Orange.

Dr. Kornfeld became a diplomate in pediatrics, and was invited to organize a child development clinic at the Coit Memorial Hospital. He organized this in 1947 and served as director of this unique clinic until the date of his death. He also was one of the group responsible for establishing the Child Guidance Clinic of the Oranges.

DR. GEORGE A. MATHEKE

At the untimely age of 51, Dr. George A. Matheke died on May 1. A life long resident of East Orange, Dr. Matheke was a 1933 graduate of the medical school of the University of Maryland. After interning at the Martland Medical Center in Newark, he did graduate work in obstetrics and gynecology, becoming a board diplomate in that specialty. He was attending obstetrician at the Newark Presbyterian Hospital as well as at Martland, and an obstetrical consultant at St. Michael's. A Fellow of the American College of Obstetricians and Gyneecologists, and an F.A.C.S., Dr. Matheke was an elder of the Brick Presbyterian Church. He was active in the affairs of the New Jersey Obstetrical Socicty and the Essex County Medical Society.

DR. BERNARD C. McMAHON

Dr. Bernard C. McMahon, past president of the medical staff of Morristown's All Souls Hospital, died there on April 25. Born in Tennessee in 1882, Dr. McMahon earned his M.D. in 1904 at the medical school of the University of Tennessee. In 1954, on the semicentennial of his graduation, that University honored him with an honorary D.Sc. degree. Dr. McMahon was a major in the medical corps during World War I, and was chief of surgery at an evacuation hospital in France. During World War II, he was chief medical examiner of the Morristown draft board and subsequently became State Chief of Emergency Medical Service for Civil Defense. An F.A.C.S., he was his county's representative on that organization's Board of Regents. He also served a term as president of the Morris County Medical Society.

DR. JOSEPH D. SEIBERLING

On May 10, death came to Dr. Joseph Dallas Seiberling, a prominent South Jersey physician. Dr. Seiberling was born in Philadelphia in 1876 and became a registered pharmacist in Pennsylvania at the age of 22. He then entered Medical-Chirurgical College from which he received his M.D. degree in 1909. After a brief period as a family doctor, he became interested in the then young specialty of otolaryngology, becoming one of the state's first board diplomates in that field. He eventually became Associate Professor of Laryngology at the University of Pennsylvania. He was active in the affairs of the Camden County Medical Society.

Announcements

National Conference on School Health

A pre-convention session on school health will be held at 7:30 p.m., Sunday, June 25, 1961, at the Park Sheraton Hotel in New York City. Theme will be "Health of the School Personnel."

Physicians concerned with school health will find the discussion partiularly significant. Schools are under examination as they have never been before; teachers and other personnel with poor mental or physical health are judged as examples of the caliber of school programs.

What are the health hazards of school employment? Who should plan the preventive program? What are the recommended methods of screening? The discussion will hope to answer these and other questions.

Speakers will be: Lemuel C. McGee, M.D., president of the Delaware Medical Society; Gerhardt Rast, Ph.D., school administrator; Mrs. Doris Field, school nurse; and George L. Cushman, M.D., family practitioner.

The meeting is open to all readers of this JOURNAL.

Prize for Drug Study Now Available

A Revere $1,000 award, to promote excellency in the reporting of clinical studies, has been announced by the Revere Publishing Company, medical journal and book publishers. The Award will be made to the senior author of the original paper published in *The Journal of New Drugs* for the coming year judged to be the best on the basis of originality and interest, design of study, conduct of trials, validity of conclusions, clarity of presentation, and general importance to the medical profession. Papers should be submitted to the *Journal of New Drugs*, 660 Madison Avenue, New York 21, New York. Additional information is available on request.

Wine Research Award

A wine research award has been established by the Society of the Friends of Wine to stimulate additional research into the medicinal uses of wine. This $1,000 award is offered to individuals or institutions who have conducted and published original research in one of the following respects: (a) identifying substances in wine, (b) ascertaining the effects of wine on living cells, tissues, or organs, or (c) indicating clinical applications of wine in the treatment or prevention of disease.

The Society's Research Committee will consider outstanding contributions and nominate possible recipients. Final selection will be determined by the Society's membership.

For further details, write to Dr. H. J. Katz at 450 Sutter Street in San Francisco.

A Course in Occupational Medicine

Occupational Medicine, a full-time course for physicians, will be given for eight weeks from September 18 through November 10, 1961 by the New York University Post-Graduate Medical School. This covers the following areas: Preventive medicine, epidemiology, biostatistics, administrative medicine, occupational diseases, and industrial hygiene. Didactic instruction will be supplemented with field trips to industrial plants, government agencies concerned with industrial health and to union health centers. Opportunity will be given to attend medical, surgical, and clinical-pathological conferences held in the New York University Medical Center. The tuition fee is $375.

For further information write to the Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was called to order by the president, Dr. Harvey Vandegrift, at the Children's Seashore House on March 10 at 9:20 p.m.

Dr. Paul Cutler introduced the speaker of the evening, Harold Rifkin, M.D., Associate Clinical Professor of Medicine at Albert Einstein College of Medicine. His topic was "Complications of Diahetes." This provoked some interesting questions from Drs. Shavelson, Cutler, and Kramer.

The business meeting began at 10:15 p.m. Charles B. Norton, M.D., of Woodstown, of the Council on Medical Services of The Medical Society of New Jersey, was introduced. He discussed the Relative Value Index which is to be used as a guide for the Society and for members dealing with the Society. It is also to be used for third parties if there are inequities. Anyone interested in reading more about RVI may refer to Page 397 of the July 1960 JOURNAL of The Medical Society of New Jersey. One objection to RVI is that it might be construed as a fee schedule.

Dr. Vandegrift appointed a committee consisting of Drs. G. Ruffin Stamps, Joseph Stella, Leonard Erber and Louis Rosenberg to review the RVI and to present their findings at the next meeting.

The regular meeting of the *Medical Society of Atlantic County* was held at the Margate Log Cabin on April 13.

There was a social hour from 6:30 to 7:30 p.m. followed by a delicious dinner provided by the Society. This was a gala evening in which the members had an opportunity to enjoy each other's company.

The business meeting was then called to order by President Dr. Harvey Vandegrift.

All committee chairmen were urged to have reports in the hands of the Secretary no later than the first week in May, so that they can be printed in the May *Bulletin*. This would save a great deal of time and inconvenience at the final business meeting of the year.

The following doctors were accepted into the Society as new members and will be sent letters of congratulation: Robert Magaziner and Peter Chodoff, Regular members; Howell E. Cook and Francesco Santucci, Associate members.

Following the business meeting, the Society was entertained by a local celebrity.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held on April 11, at Bergen Pines Hospital, Paramus, was called to order by George O. Rowohlt, M.D., President. There were 70 members present.

A certificate of membership was presented to Dr. Harry Kosovsky. Dr. John Apovian, Associate member, and Drs. Harry H. Hershey and Mark M. Singer, Courtesy members, were introduced.

Dr. Donald B. Hull, chairman of the Nominating Committee, placed in nomination the panel of officers who will be offered for election at the next meeting.

Dr. Richard P. Keating, chairman of the Program Committee, presented Dr. Jesse McCall, President of The Medical Society of New Jersey and Mr. Richard I. Nevin, Executive Officer of that Society.

Dr. McCall recounted briefly his experience as President of the State Society and urged us all to give serious and thoughtful consideration to the doctors they select to lead them in the years to come. He stated that during the past year, the State Society has been unusually active in two major areas. The first of which—resisting efforts to control fees through legislative procedures in the State Capitol—largely centered in investigations of the Dumont Commission. He warned that so far they have had a sympathetic reception but that these efforts must continue and nothing taken for granted. The second major effort has been maintaining a constant contact with organized labor. In this area a "bad press" had made things difficult. It has continually projected the doctor-image as being non-cooperative and against all proposals. On the other hand, the State Society has tried hard to find a way of sharing the distribution of medical services but have so far not been very successful.

Mr. Nevin expressed this activity a little differently. He said this year has been spent to a large extent in "standing off the aggressions of those who would pre-empt the credit of supplying medical care for their own advantage."

Dr. McCall reported that six county societies have approved the Relative Value Index in principle. One has opposed, and the others have not yet come to a decision. He believed that the Relative Value Index would be a "shield and buckler" aganst the encroachments of laymen caused by criticism of high medical fees. He assured us that The Medical Society of New Jersey would fight any effort to arbitrarily set any fees, especially the value of the basic unit of Relative Value Index. Physicians were warned to scrutinize carefully all contracts with third parties to which a fee schedule is attached.

Both Dr. McCall and Mr. Nevin were warmly applauded at the conclusion of an extremely interesting discussion.

Before adjourning the meeting Dr. Cornelius Kraissl read a resolution adopted by the Association of Military Surgeons which recommended the re-establishment of the position of Assistant Secretary of Defense (Health and Medical) and moved its adoption. This resolution was laid on the table.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

The *Burlington County Medical Society* convened in regular session at the Millside Farms Dairy Bar, Riverside, on April 13. President Boudwin called the meeting to order at 8:12 p.m. Two affiliates, 31 members 7 associates and 7 guests were present.

Our speaker was Edward Rose, M.D., Professor of Endocrinology, University of Pennsylvania, who presented "Newer Concepts of Thyroid Disease." The following guests were introduced: Dr. Bulluck; Dr. Adriano of Burlington County Hospital; and four physicians from McGuire Air Force Base: Drs. Byrne, Keller, O'Brien and Phalon.

Dr. John Lehr Ingham's application for transfer from Associate to Regular membership was presented by Dr. Bray of the Board of Censors. Drs. Murphy and Reagan were appointed tellers, ballots were distributed, voted, and counted, and Dr. Ingham was unanimously elected into Regular membership.

Oaths of membership were administered to Drs. Ashhurst and Eberly, Associate members, who were elected at our March 9th meeting, and they signed a copy of our Constitution.

The death of George N. A. Wescoat, a regular member of our Society, on March 23, was announced. In lieu of flowers, a donation of $25 had been sent to the Medical Education Fund. A memorial resolution by Dr. Summey was presented in memory of Dr. Wescoat. This resolution was made a part of the official minutes.

Announcement was made that the Camden County Medical Society, through its School Health Committee, was sponsoring a symposium on prevention of athletic injuries to school children, on May 6, in Haddonfield. Interested physicians are invited to attend.

There being no further business, the meeting adjourned at 10:25 p.m. for a snack of sandwiches, delicious pies, and Millside Farm's famous ice cream.

EDWARD D. WILDMAN, M.D.

Reporter

Gloucester

The March meeting of the *Gloucester County Medical Society* was highlighted by the presence of our guests, the pharmacists of our area. Our speaker was Dr. Peter T. Kuo, Associate Professor of Medicine at the University of Pennsylvania. He spoke on "Heart Disease and Diet." A lively discussion followed the formal presentation.

In the business portion of the meeting the treasurer's report was received. Papers of incorporation are signed and now on file. Dr. DiMarino was appointed chairman of the cardiovascular committee.

Volunteers were enrolled for Boy Scout Camp physical examinations.

Applications for membership were read from Dr. Richard Corson of Paulsboro and Dr. Francis M. O'Connor of Woodbury.

Following the business meeting a social hour was enjoyed with members of the local pharmaceutical group.

WILLIAM D. KEHLER, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof presiding, the regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on April 4. Speakers were Drs. Joseph M. Foley, Richard Chambers and Martin Goldfield of Seton Hall College of Medicine. Their subject was "The New Jersey Outbreak of Encephalitis in 1959." Many physicians participated in a discussion from the floor.

A motion was made and seconded that the Hudson County Medical Society adopt the New Jersey Relative Value Index. After considerable discussion the motion was defeated.

The following were elected to Active membership: Drs. Harper K. Hellems and Philip H. Henneman of Seton Hall College of Medicine. Dr. A. Jerene Robbins of Jersey City was reinstated to membership. Drs. Anthony N. Lamato, Alexander S. Karfopoulos, Thomas P. Massa, and Gerald Nissenbaum of Jersey City and Dr. Nicholas A. Tzimas of St. Mary's Hospital, Hoboken, were elected to Associate membership.

Following the business meeting, a collation was served.

LOUIS KOSMINSKY, M.D.

Reporter

Middlesex

Roosevelt Hospital was host to *Middlesex County Medical Society* under the leadership of its president, Dr. S. A. Gadek, on April 19. On recommendation of the Judicial-Medical Ethics Committee, the following applications were approved for presentation to the Credentials Committee of The Medical Society of New Jersey for approval: Drs. Bertram Brinsley, Perth Amboy, to Regular membership from two years of Associate membership; and Charles Di Liberti, Highland Park and Bohdan R. Kowalsky, Old Bridge, to two years' Associate membership by transfer from the Essex County Medical Society.

The membership accepted the Board of Trustees' recommendations for a compromise on the Falcone case trial bill.

Dr. George Kaufman, Director of Air Pollution, State Department of Health, Los Angeles, gave a pertinent paper on "Medical and Biologic Aspects of Air Pollution."

A panel discussion with Drs. Harry J. White and Walter Grossman as panelists, emphasized that pulmonary fibrosis is a killer in middle and older aged persons and recent evidence shows this to be due to chronic irritation.

Meeting was adjourned and collation followed.

THOMAS I. STEINBERG, M.D.

Reporter

Monmouth

The regular monthly meeting of the *Monmouth County Medical Society* was held March 22 at the Monmouth Medical Center, Long Branch. Elected to Associate membership were Drs. Gunther A. Doehner, William F. Krone, Arnold V. Scalpati, and William H. R. White, II.

A panel discussion on Social Security for physicians followed the business meeting. William J. D'Elia, M.D. was moderator and Louis F. Albright, M.D. and C. Byron Blaisdell, M.D. were panelists.

Dr. Albright spoke in favor of inclusion of physicians in Social Security. He felt this was a sound form of insurance for physicians.

Dr. Blaisdell spoke against inclusion of physicians in Social Security. He felt that doctors should resist the expansion of the Government's efforts to control the practice of medicine. By staying outside the Social Security System, we would take a consistent stand, since physicians are generally opposed to federal financing of medical care to aged, and prefer supporting medical care at the state level. Here in New Jersey any such plan of financing medical care through the federal government would result in more funds leaving the State than benefits received. It was decided to poll the entire membership by mail to see if they were in favor of or against inclusion of physicians in Social Security; and to determine if the delegates to the State Society Annual Meeting were to be instructed accordingly.

The April session was a combined meeting with the Monmouth County Bar Association and was held at Deal Golf and Country Club on April 13.

LEONARD S. DANZIG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on March 21 at 9:00 p.m. at the Clifton Casino in Clifton. Dr. F. Albert Graeter, president, called the meeting to order.

The following were elected to membership: Associate—Drs. Markian Migotski and Fortunato Ocello of Clifton; Active—Dr. Joseph J. Halleron of Paterson.

The president read the resolution on the death of Dr. Albert G. Jahn. The resolution was adopted as read.

Dr. Graeter then read a communication from Dr. Buchanan, president-elect of The Medical Society of New Jersey on committee appointments. Dr. Graeter stated that the April *Bulletin* will carry a list of the committees on which there will be vacancies. Anyone interested should call the Society office and ask that their name be submitted to the State Society for consideration.

A discussion was held on the "Pilot Plan for Eye Care on Funded Payment Basis." This Plan had been rejected by the Conservation of Vision Committee of our Society. At the suggestion of the Welfare Council it was brought up before the general membership for their consideration. A motion was passed that the Plan be published in the April *Bulletin* and an opinion requested of each member of the Society.

Dr. Graeter turned the meeting over to Dr. Jacob Freedman for our Annual Lecture in Surgery in memory of Dr. Arthur W. Van Riper. The guest speaker was Lewis M. Fraad, M.D., Professor of Pediatrics at Albert Einstein College of Medicine. He spoke on "Recent Advances in Pediatric Surgery."

A delectable buffet supper was served to the 100 members attending the meeting, with the Passaic General Hospital as hosts.

IRVING CHRISMAN, M.D.

Reporter

Salem

The regular monthly meeting of the *Salem County Medical Society* was held on March 17 at

the Du Pont Penns Grove Country Club. The presiding officer, Ford C. Spangler, M.D., called the meeting to order at 4:35 p.m.

Representatives from Anchor Hocking Glass Company and Aetna Life Insurance Company were present to discuss the experience of the Wage Disability Plan at Anchor Hocking Glass Company. Local experience was bad and the program is now in jeopardy. Chief difficulty was with women with children. This group filed 72 per cent of the claims and collected 82 per cent of the benefits. Several case histories were discussed and the Anchor Hocking representatives stated that additional supervision was to be given to examination of the claims and the entire program. He requested that local physicians complete the Disability Forms as soon as possible and forward them to the Company. He asked that physicians be as precise as possible in estimating the length of absence from work and in furnishing the diagnosis.

Dr. John S. Madara reported for the Legislative Committee and led a short discussion of the problem of Social Security for physicians.

The report of the Nominating Committee was given by Dr. Harry W. Fullerton. Those nominated included: President, Dr. William L. Sprout; Vice-President, Dr. Wilbert R. Staub; Secretary, Dr. George F. Reichwein; Treasurer, Dr. Don A. McLean; Reporter, Dr. John T. Dooley; State Delegate, Dr. C. Spencer Davison; Alternate State Delegate, Dr. John S. Madara; Nominating Delegate, Dr. C. Spencer Davison; Alternate Nominating Delegate, Dr. Harry W. Fullerton.

There being no further business, the meeting was adjourned at 6 p.m.

A special meeting of the Society was called to order by President Ford C. Spangler on April 11 at 10 p.m. at the Salem County Memorial Hospital. This meeting was called to allow Dr. John S. Madara, Legislative Keyman, to present the A.M.A. views on social security legislation. After two hours of pro and con discussion, a motion was made by Dr. Madara that the Salem County Medical Society go on record as being opposed to the King-Anderson Bill. Seconded by Dr. Eugene T. Pashuck, this passed by 16 to 4 votes.

Dr. Madara then moved that the Salem County Medical Society take active steps to oppose the King-Anderson Legislation. This opposition would be implemented by the speaker bureau, letter writing and distribution of pamphlets. This motion passed 12 to 8.

There being no further business, the meeting was adjourned at 12:34 a.m.

The regular monthly meeting of the *Salem County Medical Society* was held on April 21 at the Du Pont Penns Grove Country Club. The meeting was called to order at 4:40 p.m. by the president, Ford C. Spangler.

The minutes of the previous meeting were read and approved. Committee reports from the various chairmen were received and filed with the secretary.

Dr. William Sprout reported on the Annual Shad Dinner. He gave a resume of the menus available.

A report was received from the Salem County Guidance Clinic. Members agreed that the service was well accepted and that reports of patients were returned promptly.

Following a short discussion of the proposed changes in the Constitution and Bylaws, Dr. C. Spencer Davision moved that they be accepted as proposed. The motion was passed unanimously. Dr. Davison then moved that revision be made to include certain stipulations regarding residency and clarification of those eligible for membership in the county society. This motion was also passed unanimously. A committee was appointed by Dr. Spangler to consider the revision of the Bylaws. This committee includes Drs. C. B. Norton, J. Dooley, and R. Carter.

A recent newspaper clipping questioning the adequacy of the "Emergency Call Service" was read. This precipitated a lively discussion. Dr. Isadore Lipkin moved that the Public Relations Committee investigate complaints directed against the Society members and make a report to the Society for the purpose of correcting any deficiencies present. This motion carried unanimously.

Dr. John Dooley announced the Mental Health Fund Drive to be held in May.

Dr. William Sprout announced that a Civil Defense Drill would be held April 23. All First Aid Squads in the County will take part in this as will a number of members of the Society. It was also announced that a conference on Disaster Medical Care will be held on June 24.

There being no further business, the meeting adjourned at 6 p.m.

G. F. REICHWEIN, M.D.

Reporter

New Jersey Dermatological Society

The *New Jersey Dermatological Society* held its annual meeting at the Newarker Restaurant on May 9. The following were installed as officers for 1961-1962:

President—Samuel Atkinson, M.D., Summit; First Vice-President—Hugh McCulloch, Jr., M.D., North Plainfield; Second Vice-President—Jacob Bleiberg, M.D., Irvington; Treasurer—Morton Kulick, M.D., Paterson; Recording Secretary—John Hunt, M.D., East Orange; Corresponding Secretary—Martin H. Wortzel, M.D., Newark.

A certificate was presented to the retiring President, Samuel D. Kaplan, M.D., of Elizabeth.

MARTIN H. WORTZEL, M.D.

Corresponding Secretary

Mrs. Floyd D. Gindhart: Auxiliary President

Your new State President has had the rare privilege of receiving her professional nurses' training in the hospital in New York City in which she had been born and baptized.

On July 22, 1917 Mary Theresa O'Grady was born at Misericordia Hospital. Following graduation from Cathedral High School in Manhattan, she entered the Misericordia Hospital School of Nursing in 1936, and received her professional degree R.N. from the State of New York in 1939.

During World War II she served in the U. S. Navy Nurse Corps for eighteen months and was stationed at the Balboa Naval Hospital in San Diego, California and Treasure Island Naval Dispensary in San Francisco. When she and Commander Floyd D. Gindhart (MC) USNR were married in January 1943, it was the occasion of one of the first weddings of a Navy doctor and Navy nurse in uniform. Prior to his Naval Service Dr. Gindhart had his professional offices in New York City. On discharge from active duty, the Gindharts settled in Trenton in 1946. They have three sons, Donald, Brud and Bob and two granddaughters, Valerie and Joan.

Mary became a member of the Woman's Auxiliary to the Mercer County Medical Society in 1947 and served two years as President in 1953 and 1954. She has been on the State Board as a member of the Editorial Board of the *News-Note* since 1951 and as Editor of the *Newsletter* from 1953 to 1958. She has been State Chairman of Membership. Mrs. Gindhart has also been Program and Conference Chairman.

An active member of the Helene Fuld Hospital Auxiliary Board, she has served as President of the Auxiliary for three years. She has been on the Trenton Visiting Nurse Association Board since 1950 and was President of that agency from 1953 through 1955. She is now Assistant Treasurer there and is on the



Board of Governors of the Greater Trenton Symphony. Mrs. Gindhart belongs to the Contemporary Club; Delbarton Mothers Guild; Blessed Sacrament PTA; Misericordia Nurses Alumnae and American Legion Post No 447. She is a charter member of the Woman's Auxiliary of the International College of Surgeons; of the Charter Study Committee of Trenton; and of the Donnelly Memorial Hospital's Auxiliary.

When she is not answering the telephone for a busy mate who is an obstetrician-gynecologist, or chauffeuring boys, or preparing meals, Mary enjoys swimming, traveling, amateur oil painting, reading or playing the organ for her own amusement.

Book Reviews

French's Index of Differential Diagnosis. Edited by A. H. Douthwaite, M.D. Baltimore 1960. Williams and Wilkins. Ed. 8. Pp. 1112. ($24.00)

The designation "classic" is often tossed around casually. French's, however, *is* indeed a classic. Since it was first issued in 1912, this has been the diagnostic bible for many generations of Americans and British medical students. Presenting symptoms are arranged alphabetically from Accoucheur's Hand (a sign of tetany) to Weight, Loss of. Under each entry is a discussion of possible causes with a compact presentation of diagnostic differential features. Then there is an index to the index—a 150-page section with a total of some 40,000 entries (that's right: 40,000) running the gamut from abacterial cystitis to zymotic diseases. This kind of manual will swiftly earn its space on any practitioner's desk. Additional praise from this reviewer hardly seems necessary. A half-century of applause from students and physicians has given French's its accolade.

VICTOR HUBERMAN, M.D.

The Merck Index of Chemicals and Drugs. Edited by Paul G. Stecher, Rahway, N. J., 1960. Merck and Company. Pp. 1641. 7th Ed. ($12.00)

In 1889 Merck published its first "Index of Chemicals and Drugs for the Materia Medica." The foreword of that edition closed with: "May this book be a welcome visitor, so useful as to be asked to come again." The wish has been fulfilled, and the *Index* has been part of our pharmaceutical literature for the past 70 years.

This seventh edition includes a wonderful alphabetical cross-index of 30,000 names enabling the user to locate the desired data whether he starts with brand name, chemical designation or generic name. The book includes 10,000 little monographs of individual substances. Included, too, is a modern periodic table, and a 225-page appendix chock full of useful information: conversion tables, tests, specific gravities, boiling temperatures, logarithms, percentage tables, and—even the Russian alphabet. To physicians who think that medicines are the proper business of Medicine, this is an enormously useful reference work.

ULYSSES M. FRANK, M.D.

Medical Research and the Death Penalty. Jack Kevorkian, M.D. New York 1960. The Vantage Press. Pp. 75. ($2.50)

In the last analysis, successful medical research demands experimentation on the living human body. Neither animal studies nor dissections or corpses will fill the bill. Some very courageous chapters have been written in medical history by physicians and other scientists who have submitted themselves to experimentation. Dr. Kevorkian (a pathologist) argues that criminals condemned to death should be given the opportunity to offer their bodies for research with the understanding that the experimental work would be done while they were under deep, intravenously induced, anesthesia. At the conclusion of the experiment, a lethal dose of the anesthetic agent would be introduced. It is argued that this is painless, humane, and gives the condemned man a sense of usefulness. The book is cast in the synthetic mould of a dialogue between antagonist and protagonist and, of course, protagonist wins. Its impact would have been better had the author offered it as a straight essay, answering the opposing arguments on a one by one basis. However, Dr. Kevorkian is quiet, objective and logical and is certainly not a fanatic. In pure logic, his thesis is unanswerable. Unfortunately, people are not logical. One wonders if the deep horror at vivisection (even when the subject is fast asleep) can be exorcised by the doctor's excellent logic. The Nazi experiments in human vivisection are still remembered. While Dr. Kevorkian's plan is entirely different in aim, method and motivation, the project itself will produce this kind of reaction. The book is provocative, challenging and thought-stimulating.

HENRY A. DAVIDSON, M.D.

De Lee's Obstetrics. J. P. Greenhill, M.D. Philadelphia, 1960. Saunders. Ed. 12. Pp. 1100 with 1219 illustrations. ($17.00)

It is gratifying to see how the superb intelligence and teachings of Joseph De Lee have evolved into present-day obstetrics as exemplified in Greenhill's book. Those familiar with the *Year Book of Obstetrics and Gynecology* will not be surprised to find in this text a complete familiarity with the latest literature and advanced thought.

At last taboos against swimming, tub-bathing and coitus during late pregnancy have been lifted. Perhaps the next edition will also delete the erroneous proposition that nocturnal leg cramps are due to excessive phosphorus. The short discus-

sions of therapeutic abortion and sterilization ignore the psychiatric, social and economic aspects of the problems which, although controversial, should certainly have been mentioned. I cannot understand why two full pages should have been devoted to the detailed use of the metreurynter, a device which long ago should have been relegated to a museum of medical horrors. I also cannot understand the perpetuation of the concept that there is a mild eclampsia as opposed to a severe eclampsia.

These and other minor defects do not detract from the excellence of this new text-book. The late Dr. Herbert E. Schmitz's chapter on medico-moral problems will be welcome to those unfamiliar with or misinformed about the position of the Catholic Church on so many moral problems arising during day by day practice of obstetrics. Robert Berman's section on obstetric roentgenology is most welcome. Dr. Israel Davidsohn's chapter on fetal erythroblastosis is most thorough and not too complex for even the medical student to comprehend. On the whole this book cannot be too highly recommended to all students and practitioners of obstetrics.

AARON LOWENSTEIN, M.D.

Light Coagulation. By G. Meyer-Schwickerath, M.D. Translated from the German by Stephen M. Drance, M.D. St. Louis 1960. Mosby. Pa. 114. With 55 illustrations. ($9.50)

The Zeiss light coagulator was developed in cooperation with the author's experimental work and clinical study. His basic work in the perfection of a new method of treatment in ophthalmology is presented in this book which opens with a good summary of the historical background and of the basic physiology of light coagulation. Dr. Meyer-Schwickerath then describes the apparatus and offers information about using it and about the preparation and handling of prospective patients.

Indications for light coagulation are discussed, classified, and supported with case histories. The author reviews the sealing of retinal tears and holes; equatorial degenerations, perforating wounds; destroying retinal tumors, aneurysms, proliferations, inflammatory lesions, iris and surface neoplasms.

Contra-indications, complications, limitations, and hazards are pointed out. The advantages of this method are high-lighted: freedom of repeated application to the exact site of the lesion with the help of the ophthalmoscope which is an integrated part of the unit, and the freedom from inducing lens damage with the therapeutic intensity of radiation.

The Zeiss light coagulator is already on the market. Ophthalmic centers should want to apply this new therapy. Here is first hand information in clear translation.

BELA SZINEGH, M.D.

Resuscitation of the Newborn. By 25 contributors. Edited by Harold Abramson, M.D. St. Louis, 1960. Mosby. Pp. 275 with 36 figures. ($10.00)

At one time, efforts at resuscitation of the newborn were so vigorous that the helpless infant might have been unnecessarily traumatized. Now, Dr. Abramson suggests, the pendulum has swung and we are doing too little rather than too much. This book is a collaborative effort to furnish practical tips on the problem. More than that, it also provides a fine physiologic and laboratory background, so that this is not simply a "how to do it" manual. The text covers an appraisal of all influences affecting baby's vitality—before conception, during pregnancy, at the time of labor and so on. Into less than 300 pages, it packs an encyclopedia of useful information on the most important salvage operation of our time: the saving of new human lives.

RALPH N. SHAPIRO, M.D.

Psychological Techniques in Diagnosis and Evaluation. Theodore C. Kahn and Martin B. Griffen. New York, 1960. Pergamon Press. XI plus 164 pp. ($6.50)

This book is directed at giving those whose professions involve contact with clinical psychologists some idea of "what a psychologist is, how he functions, and how he arrives at his conclusions." The text is to be highly praised for its brevity of exposition and simplicity of language.

The reader is presented with relevant information on the background and training of the clinical psychologist and is made aware of some of the ways in which psychology can contribute to pediatrics, internal medicine, neurology, psychiatry, and vocational and educational counseling. He is introduced to a fair sample of some of the more widely used tests: Rorschach, Thematic Apperception Test, Wechsler Intelligence Tests, Bender Gestalt, Goldstein-Scheerer Tests, Kahn Test of Symbol Arrangement and several others.

Kahn and Griffen use an interesting approach, by tying in test description with practical diagnostic problems in schizophrenia, mental deficiency, psychoneurosis, intracranial pathology, psychosomatic disorders, and educational and vocational guidance. The major portion of the book is devoted to topics which generally fall within the jurisdiction of psychiatrists and neurologists. One might thus infer that it is for these specialists that the text is primarily intended. From the point of view of this behaviorally sophisticated audience, the reader is likely to be left with the feeling that he has been served a rather thin cup of tea. There is too much emphasis on a static "sign" approach to diagnosis and not enough on the underlying psychologic theories of behavior which are crucial to a meaningful understanding of the tests.

As opposed to such standard elementary texts in the field as Anderson and Anderson: "Introduction to Projective Techniques" or Cronbach: "Essentials of Psychological Testing" this volume has little to offer the reader interested in acquiring an intelligent grasp of some of the theoretical and practical aspects of psychodiagnosis. The reader whose contact with clinical psychology is more cursory, however, will find the book both interesting and informative.

HAROLD N. HANSEN, PH.D.

Transplantation of Tissues. Edited by Lyndon A. Peer, M.D. Baltimore, 1959. Williams and Wilkins. Volume II. ($20.00)

This second volume represents the combined efforts of twelve contributors on as many subjects in the field of tissue transplantation. Included are sections on skin, cornea, fat, nerves, teeth, blood vessels, endocrine glands, organs, peritoneum and cancer cells.

Dr. Peer explains that "each contributor to this volume describes how tissue, organ or gland transplants may be grafted and the success, limitation or failure of the procedures." The authors present their subjects from an experimental and clinical approach with exceptional clarity. It is difficult to pick out one particular part, as the book is full of valuable instruction.

The bibliographic references are extensive and the book represents a summary of current knowledge in a rapidly expanding field. This is an outstanding book related to plastic surgery and should prove useful to anyone interested in tissue transplantation.

JEROME GELB, M.D.

Adventure to Motherhood. By Allan Offen, M.D. New York 1960. Taplinger Publishing Co. Pp. 68. ($2.95)

This delightful little book was written for young couples traveling the wonderful road to parenthood. It takes the reader on a day-by-day journey from the time they hopefully "suspect" to the happy day when they first see their newborn child.

Color photographs show each important step in a way charmingly understandable to these young prospective parents. There is much clear, reassuring advice about such practical and important matters as diet, exercise, clothing, posture and weight. Other dramatic photographs provide lucid and spectacular visual presentations all along the way, including the actual birth.

The book is qualified to allay fears, disprove old-wives tales and to answer the questions common to the mothers and fathers of tomorrow; especially for those on their first journey. This was the author's expressed intent and this he has accomplished.

Adventure to Motherhood is small, readable, and can be heartily endorsed for distribution by busy physicians to replace or supplement time-consuming repetitious office explanations; accomplishing the desired end better possibly than the office nurse or the obstetrician who, after many years, steeped in obstetrics, find it difficult to place themselves in the position of this starry-eyed couple who should be given supportive reassurance as well as all possible safety-insuring information.

MARY BACON, M.D.

Complications of Surgery and Their Management. By Curtis P. Artz, M.D. and James D. Hardy, M.D. (with contributions by 69 authorities). Philadelphia 1960. Saunders. Pp. 1075, illus. ($23.00)

This interesting book encompasses much more than the title would indicate. It is not just a "How-to-do-it" surgical text; it is based on a thorough exposition of normal and pathologic physiology.

The first third of the book is of interest to every surgeon and would warrant being published as a separate volume, should this work be enlarged in later editions. The subject matter concerns every surgeon regardless of specialty. The later chapters are devoted to specific problems in special fields.

As in all works by multiple contributors, there is an unevenness of material and of writing; since each author views the problems from one aspect only. This is particularly true in the early more general chapters, where recommendations are occasionally somewhat contradictory. Nevertheless, this book is highly recommended as a valuable addition to any surgeon's libarary.

SAMUEL J. LLOYD, M.D.

Tensions and How to Master Them. By G. S. Stevenson, M.D. and Harry Milt. New York, 1960. Public Affairs Pamphlet 305. Public Affairs Committee ($0.25)

An awful lot of common sense is packed into this 28-page pamphlet. The authors are affiliated with the National Association for Mental Health. The material, presented in breezy, down-to-earth fashion (with no sacrifice of scientific accuracy) discusses tensions and anxieties and what you can do about them. The booklet is excellent for any physician called on to give a talk to a lay group; and is appropriate to recommend to patients suffering from tension states.

ABRAHAM LEFF, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JUNE, 1961 • VOL. XXXIV, NO. 6

DRUG RESISTANCE IS INCREASING

Studies in the United States and in Great Britain show that drug-resistant tuberculosis in previously untreated patients is on the increase. The public health as well as the clinical implications of this problem must be considered in planning programs in the future.

If tuberculosis is to be eliminated, timing is vital. The principal drugs, streptomycin, isoniazid, and PAS (para-aminosalicylic acid) must be brought to bear while their potential is still at its height and before their value goes swirling down the drain with the widespread emergence of drug-resistant strains of tubercle bacilli.

The present situation with respect to infection by drug-resistant tubercle bacilli is by no means entirely clear.

In 1952, the Veterans Administration-Armed Forces Study Group reported on the initial streptomycin susceptibility pattern of more than 2,000 tuberculosis patients admitted for treatment during the previous year who had no prior chemotherapy. Just over 2.5 per cent of these patients yielded cultures showing "primary," or pretreatment, resistance to streptomycin. It was concluded that streptomycin-resistant tubercle bacilli, however much of a clinical problem they might be, had not yet become an epidemiologic factor of importance.

INCIDENCE UP

In the Veterans Administration-Armed Forces 1957 study, the incidence of drug-resistant tubercle bacilli in untreated patients was up to 5 per cent. The Medical Research Council of Great Britain in a similar survey of previously untreated patients found primary drug-resistant strains in almost 4 per cent of those tested.

Later reports are even more disquieting. In 1958 two committees of the International Union Against Tuberculosis studied the occurrence of drug-resistant tubercle bacilli in patients admitted consecutively to 72 tuberculosis treatment centers in 17 different countries of Asia, Europe, North and South America. Among 1,400 patients who had had no chemotherapy prior to admission, the incidence of drug-resistant tubercle bacilli ranged from 2.7 per cent to 19 per cent and averaged 6.5 per cent. The United States was well above the average with 8.7 per cent. Simultaneous resistance to two drugs occurred in 1.5 per cent; resistance to all three drugs was rare, but all five cases reported were from the United States.

The incidence of bacilli resistant to streptomycin, isoniazid, and PAS in patients with no history of previous treatment is, therefore, on the increase. If the 8.7 per cent incidence is correct for the nation as a whole, and if we have 75,000 new active cases of tuberculosis reported annually in the United States for the next few years, then each year at least 6,000 of the new cases will yield bacilli resistant to one or more of the three major drugs; roughly 2,500 resistant to isoniazid, 2,500 to streptomycin, and the remainder to PAS.

The U. S. Public Health Service has calculated that among the 36 million individuals in this country now infected by tubercle bacilli

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JAMES W. RALEIGH, M.D., *Bulletin of the National Tuberculosis Association*, January, 1961.

but not yet ill, the new active case rate will be approximately 85 per 100,000 population per year for the next four or five years. If these relationships hold true, 6,000 new active cases of tuberculosis with drug-resistant bacilli are actually a reflection of more than 7 million individuals now infected by such bacilli, but not yet manifestly ill with tuberculosis. If the evolution in this group from infection to disease is more frequent or more rapid than usual, the population infected with resistant bacilli may be less than 7 million; if, on the other hand, this transition in those infected with resistant bacilli (particularly isoniazid resistant) is slower or less frequent, the reservoir of drug-resistant tuberculous infection may be even greater than 7 million.

Thus, it seems inescapable that in the drug resistance being discovered with increasing frequency among previously untreated patients, we are seeing only that small segment of the iceberg that rears above the surface.

WHAT PRICE RESISTANCE?

What can be done about this trend? The first step, of course, is to recognize that the emergence of drug-resistant tubercle bacilli is not merely a clinical handicap, but also an epidemiologic fact. Our attitude toward drug resistance must be refocused to recognize its broad public health implication as well as its disadvantages to the individual patient.

Chesterton, in one of his famous paradoxes, is quoted as saying, "Whatever is worth doing is worth doing badly." We sometimes seem to adopt this point of view in insisting that inadequate treatment of tuberculosis is better than no treatment at all. Token treatment with isoniazid alone has been prescribed for patients all over the world, many of them with far advanced tuberculosis, extremely poor nutrition, and socio-economic burdens of crushing magnitude. We will not cure them, we have argued, but a few months of bacteriologic remission and of clinical improvement is justified on public health grounds.

We must now begin to ask ourselves whether widespread infection by drug-resistant tubercle bacilli isn't too high a price to pay for such transitory benefits. What has always been recognized as inferior treatment from a clinical point of view seems now to be losing its justification from the public health point of view. The administration of isoniazid to patients who have no real chance of achieving complete control of their disease with this drug alone may be short-sighted public health practice as well as second-rate medicine.

Even in underdeveloped areas, the continued use of inadequate chemotherapy as a public health measure is not being recognized for what it is—a two-edged sword which may make the eventual control of tuberculosis in those areas more rather than less difficult than it need be.

Clinicians, too, need to sharpen their public health perspective in prescribing treatment. In planning the treatment of newly-diagnosed patients, information about the drug susceptibility of patients' organisms is essential. With the growing possibility of drug-resistant infection, pretreatment drug susceptibility studies are essential. Much of the delay and much of the reluctance of clinicians to wait for this information before starting treatment could be avoided if susceptibility studies were started routinely on the diagnostic sputum examination.

If for any reason one cannot await the results of pretreatment susceptibility tests, one may initiate treatment with a second-time combination, such as cycloserine and viomycin, or initiate treatment with all three major drugs, each given daily. In either instance, substantial therapeutic progress can be made with little risk and without hazarding the loss of susceptibility to one of the major drugs. Once the laboratory information is available, the drug treatment can be tailored to provide the most effective combination for the patient's specific needs.

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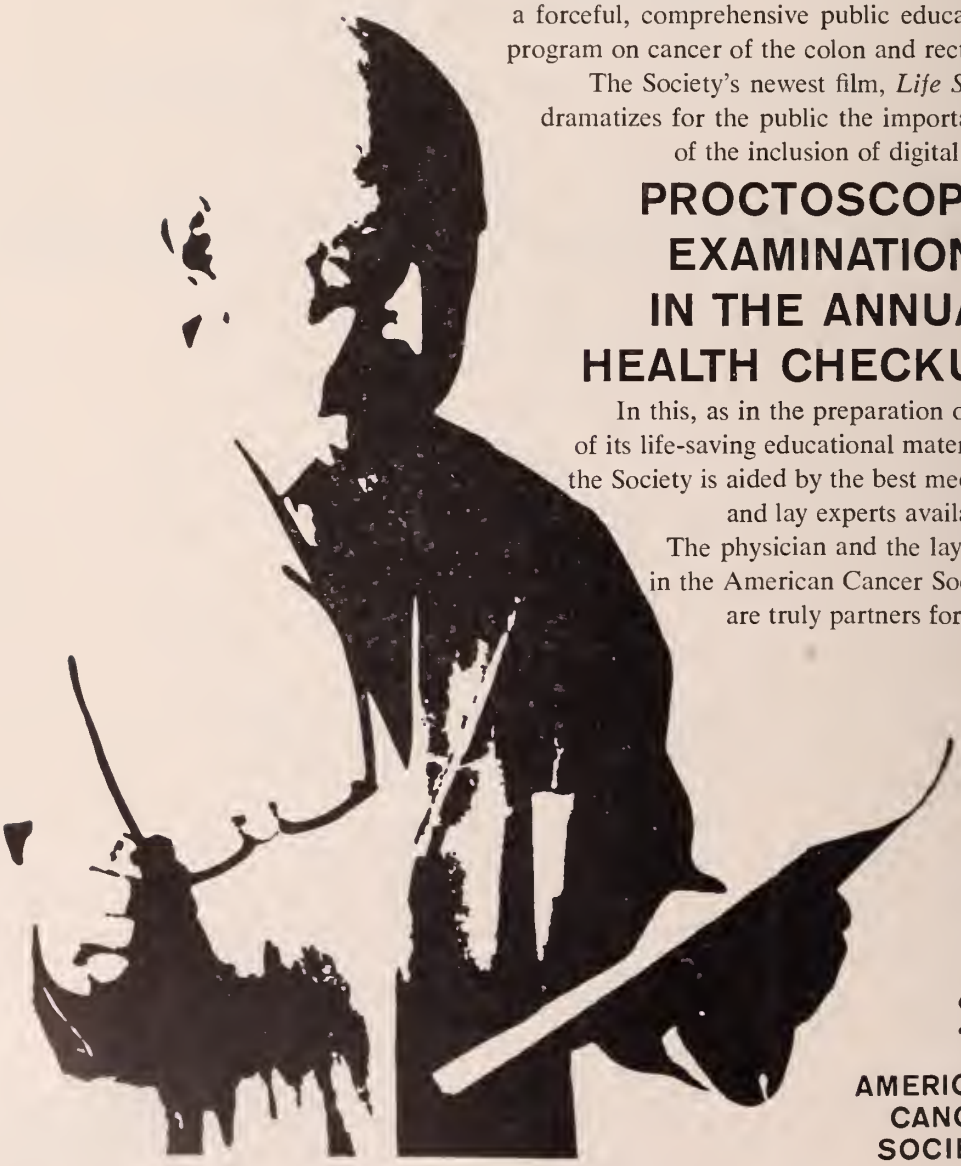
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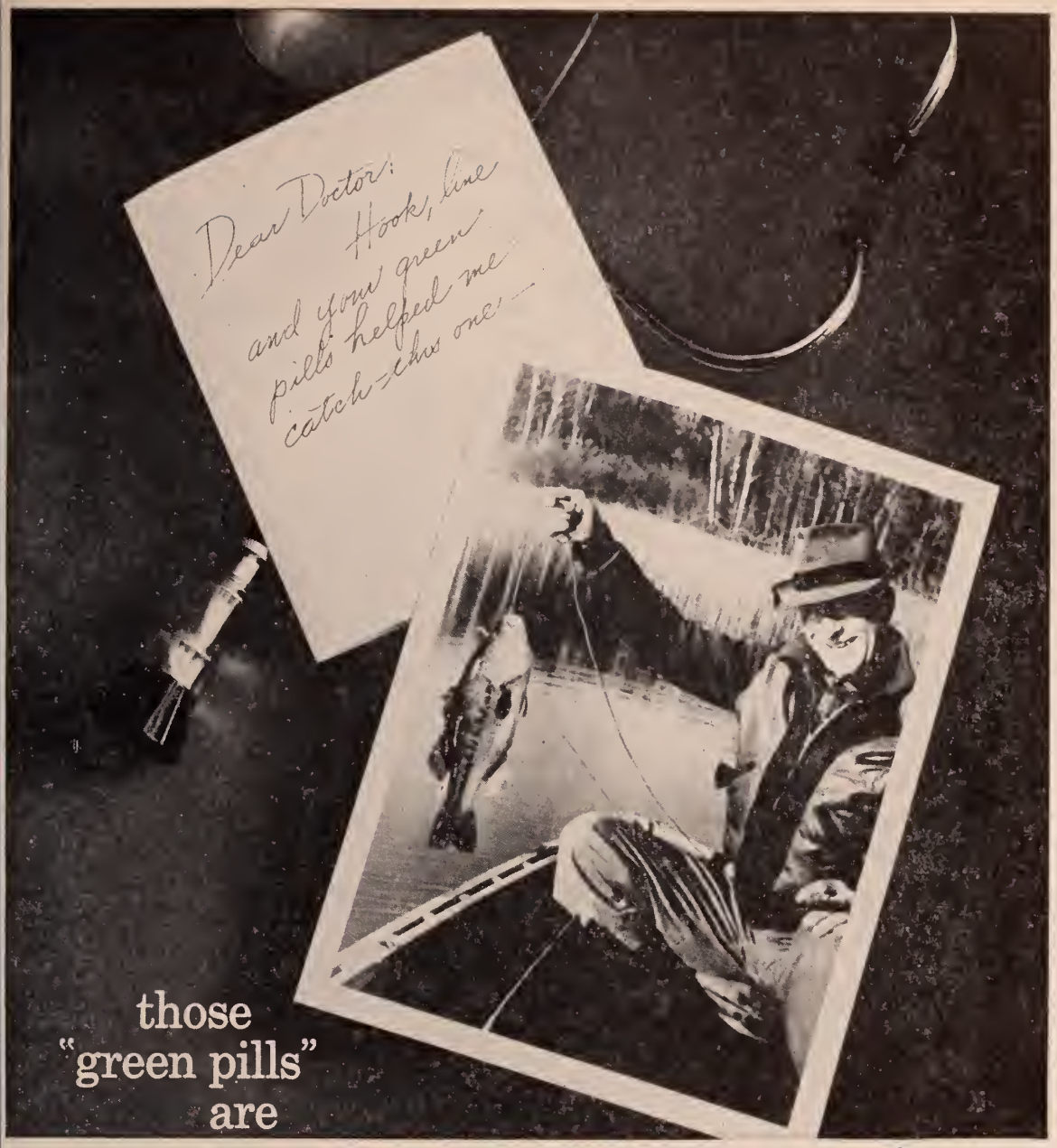
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Place	Name and Address	Telephone
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BLACKWOOD	Worrell's Pharmacy, 12 So. Black Horse Pike	CAnal 7-0430
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BLOOMFIELD	Jay W. Clark, Pharmacist, 170 Broad St., Belleville Ave.	PIlgrim 3-4150
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EATONTOWN	Town Pharmacy, 17 Main St.	LIberty 2-0547
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
ENGLEWOOD	Pastor Pharmacy, 546 Grand Ave.	LOwell 8-9378
FARMINGDALE	Burke Rexall Drugs, Main St. opp. Bank & Post Office	WEbster 8-9051
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
FREEHOLD	Wood's Pharmacy, 2 E. Main St., cor. South	FReehold 8-0668
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	DElaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
LITTLE FERRY	Copello's Drug Store, 229 Main St.	DIamond 2-5534
MILLTOWN	Family Prescriptions, Inc., 122 North Main St.	MIlltown 8-1321
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BEImont 5-0088
MORRISVILE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	G. Maggio's Prescription Pharmacy, 136 Fleming Ave.	MItchell 2-8915
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	7th Avenue Pharmacy, Inc., 71 - 7th Ave.	HUmboldt 3-7676

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(Continued from preceding page)

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ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
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PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
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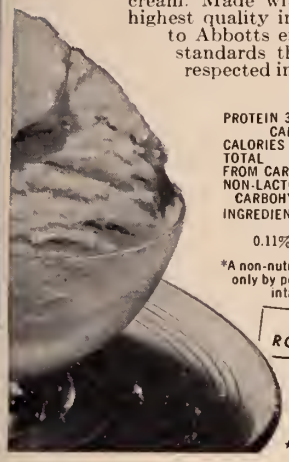
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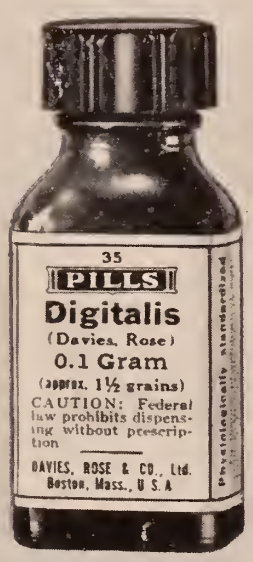
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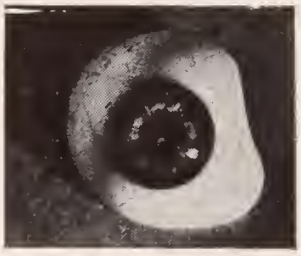
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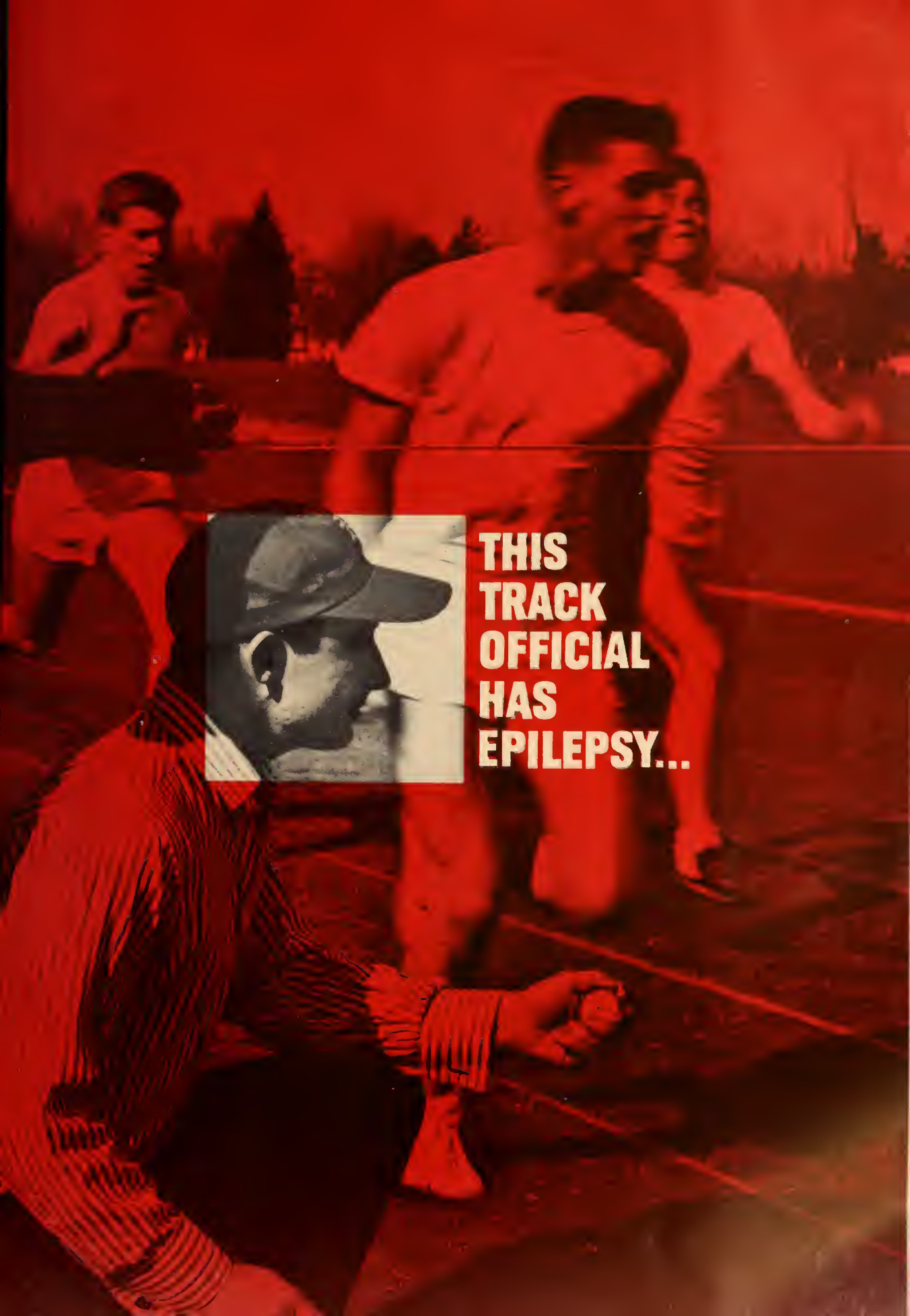
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(1) Carter, S.: M. Clin. North America 37:315, 1953.
(2) Maltby, G. L.: J. Maine M. A. 48:257, 1957.
(3) Crawley, J. W.: M. Clin. North America 42:317, 1958.

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1. The Composition of Milks, Publication 254, National Academy of Sciences and National Research Council, Revised 1953.
2. Brown, G.W.; Tuholski, J.M.; Sauer, L.W.; Minsk, L.D., and Rosenstern, I.: J. Pediat. *56*:391 (Mar.) 1960.

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Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 58, NO. 7 JULY, 1961 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154



Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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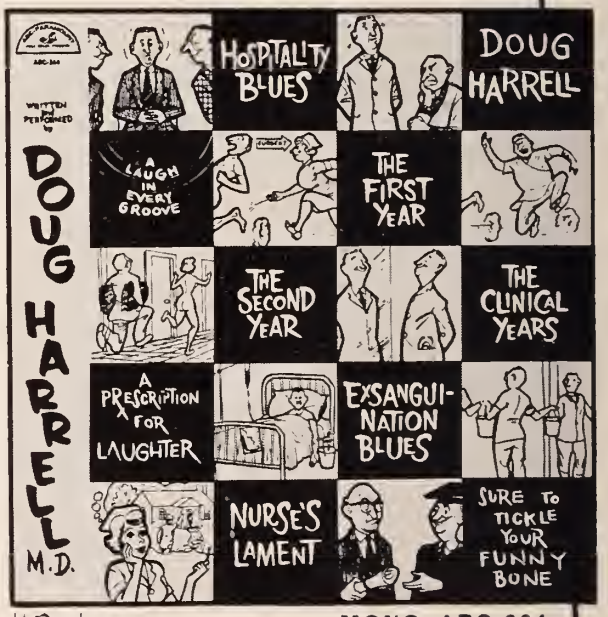
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References: 1. Garber, R. C.: J. Florida M. A. *45*:549 (Nov.) 1958. 2. Lipton, M. I.: Pennsylvania M. J. *64*:60 (Jan.) 1961. 3. Ayd, F. J., Jr.: Psychotropic Drugs, S. Garattini and V. Ghetti, eds., New York, Elsevier Publishing Co., 1957, p. 548. 4. McGettigan, D. L.: West. Med. *1*:8 (Jan.) 1960.

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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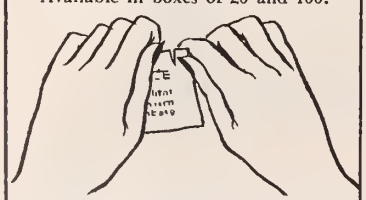


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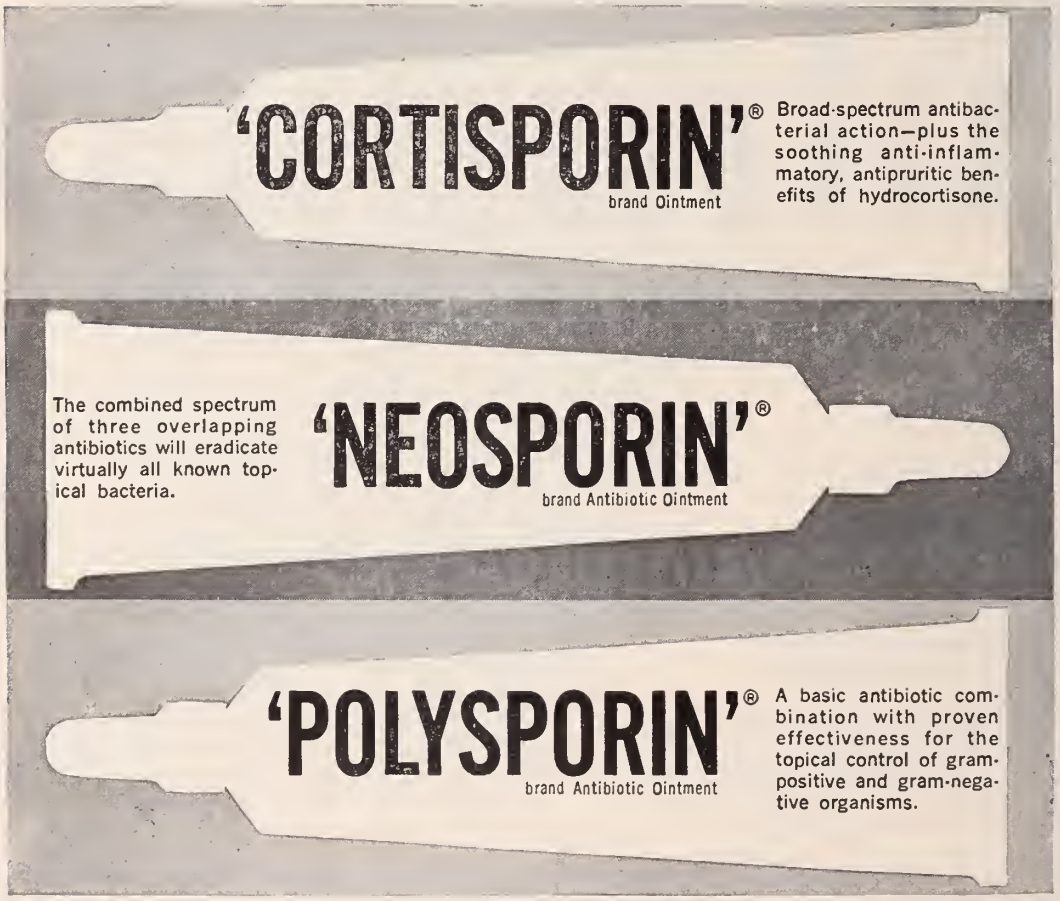
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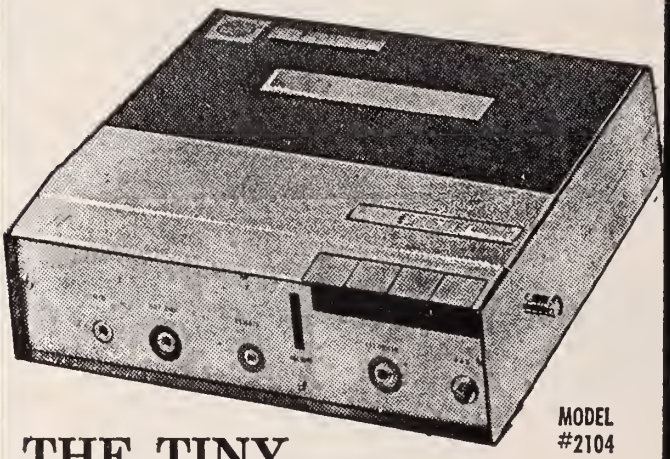
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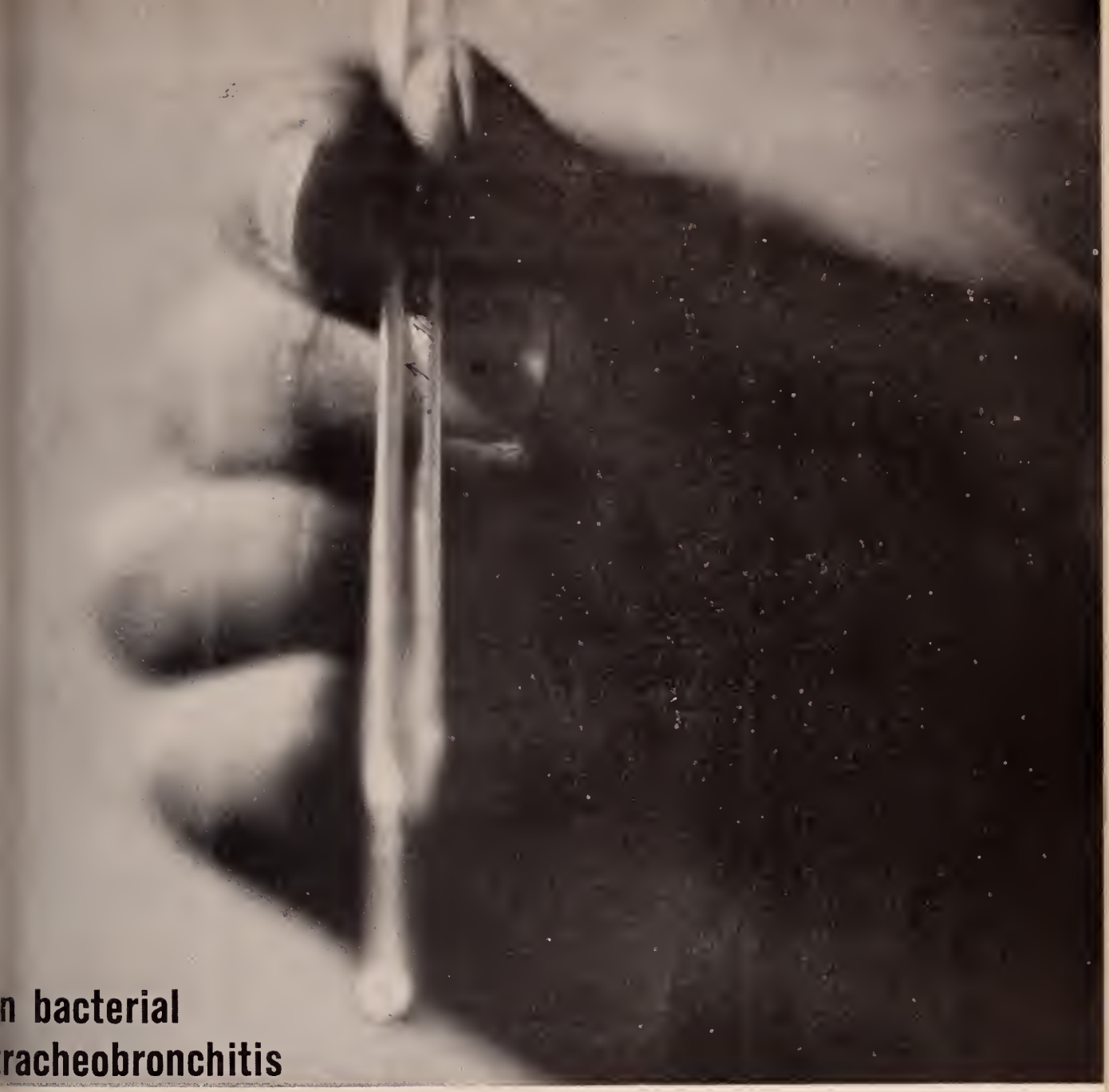
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Urticaria and maculopapular dermatitis, a few cases of leukopenia and agranulocytosis have been reported in patients treated with Albamycin. Most of these side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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You will find this book invaluable for treating patients with elevated serum cholesterol.

Complete menus for 10 days enable you to prescribe diets which are appetizing, nutritiously adequate and which can exert cholesterol depressant activity. Special attention has been given to constructing the menu patterns so that they adhere as closely as permissible to the patient's normal eating habits.

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Weight control is achieved as each day's menu is given at 3 calorie levels—1200, 1800 and 2600 calories. You prescribe the level most desirable and modify as desired.

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Complete recipes—65 in all—are included to assure that the specified menus provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, plus essential nutrients.

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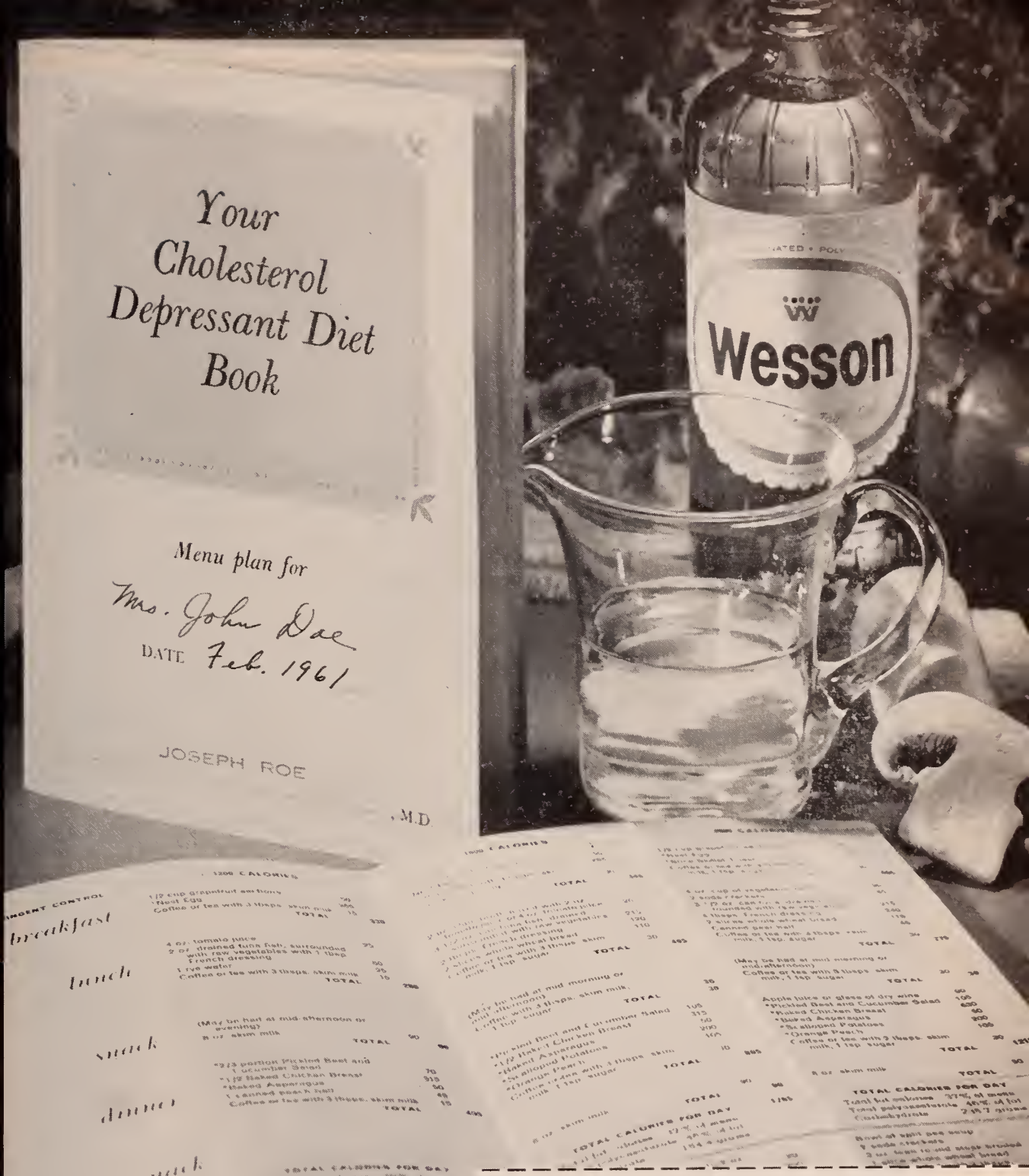
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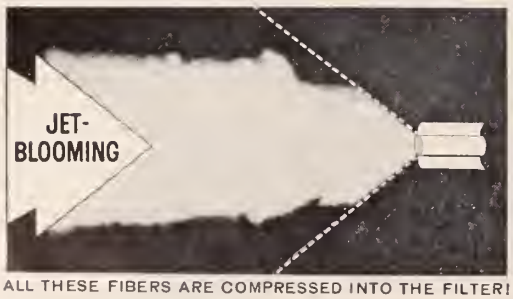
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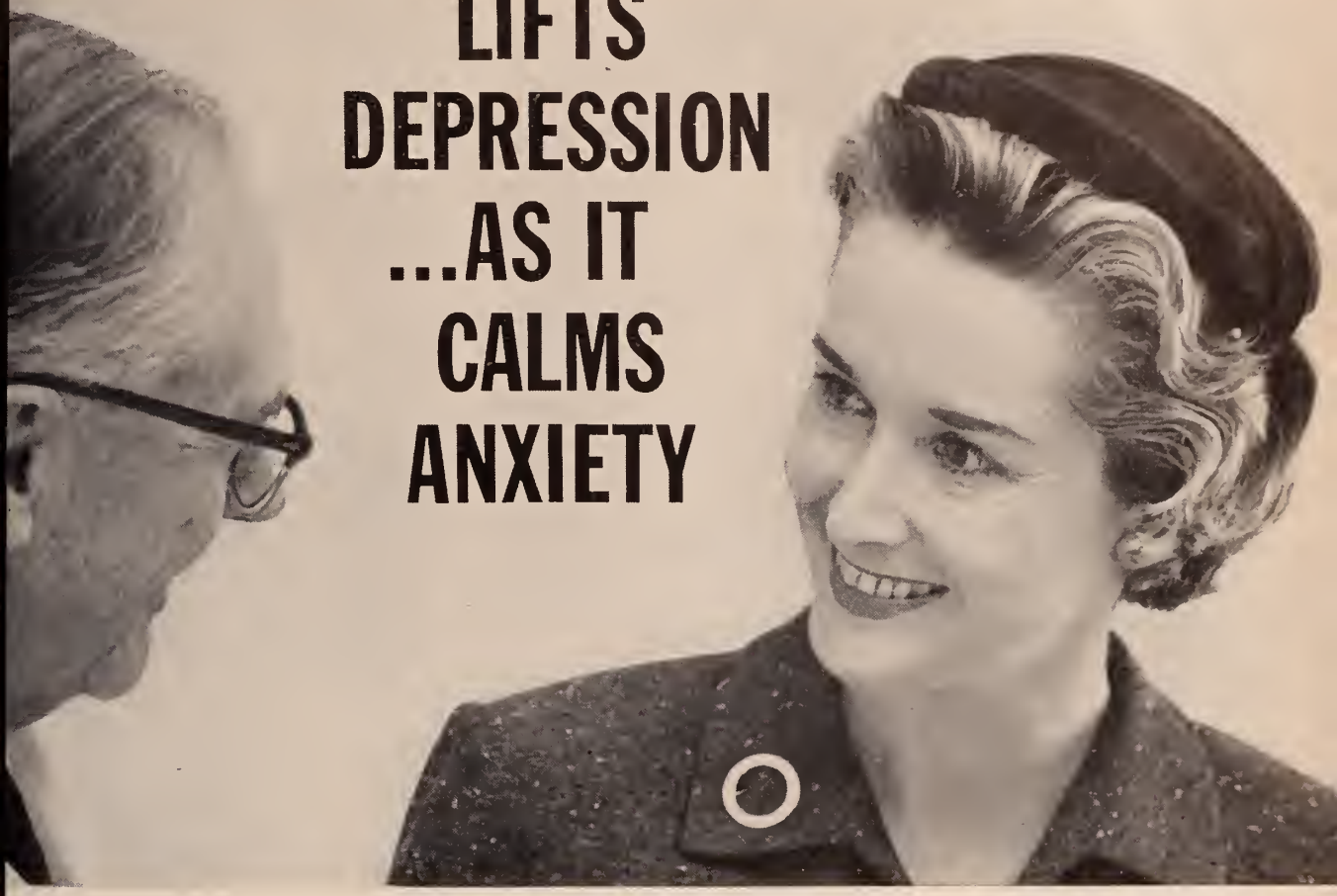
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Dosage: Usual starting dose is 1 tablet q i.d. When necessary, this may be gradually increased up to 3 tablets q i.d.
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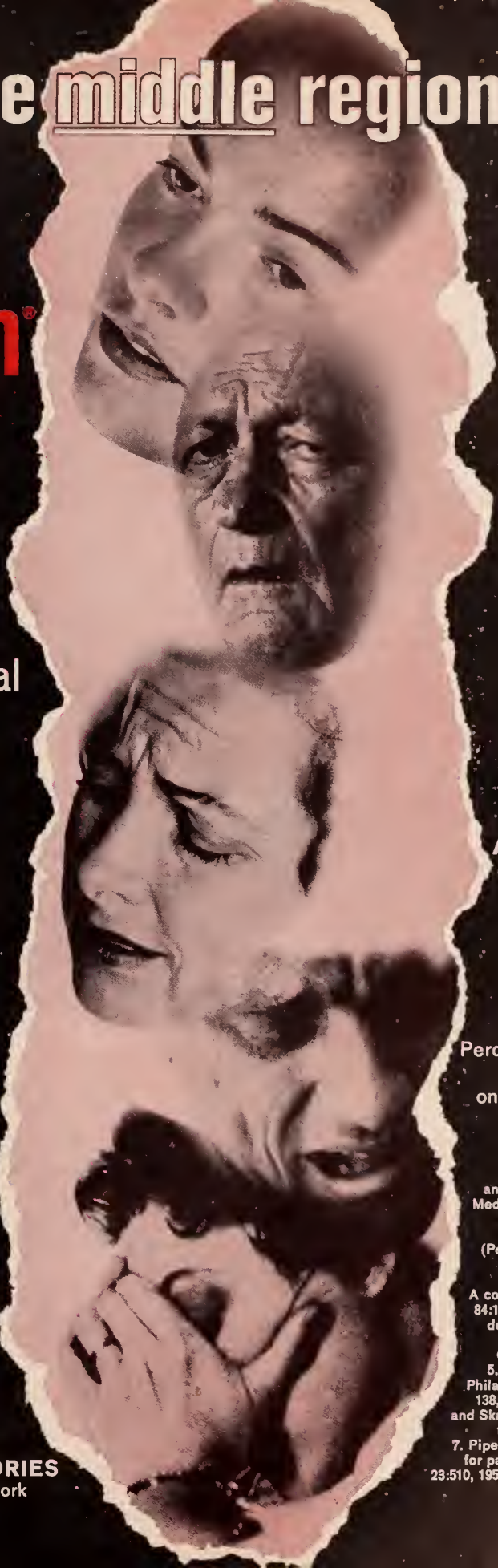
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1. Blank, P., and Boas, H.: Improved analgesia for moderate pain, Ann. West. Med. & Surg. 6:376, 1952. 2. Bonica, J. J., et al.: The management of postpartum pain with dihydrohydroxycodeinone (Percodan): Evaluation with codeine and placebo, West. J. Surg. 65:84, 1957. 3. Cass, L. J., and Frederick, W. S.: A controlled study in pain relief, M. Times 84:1318, 1956. 4. Chasko, W. J.: Pain-free dental surgery: Postoperative extension of the pain-free state, J. District of Columbia Dent. Soc. 31:3, No. 5, 1956. 5. Cozen, L.: Office Orthopedics, ed. 2, Philadelphia, Lea & Febiger, 1953, pp. 120, 138, 145, 156, 234. 6. Nicolson, W. P., Jr., and Skandalakis, J. E.: Control of postoperative pain, J.M.A. Georgia 46:471, 1957. 7. Piper, C. E., and Nicklas, F. W.: Percodan for pain in industrial practice, Indust. Med. 23:510, 1954; abstracted, Clin. Med. 3:1008, 1956, Current M. Digest 22:135, No. 3, 1955.

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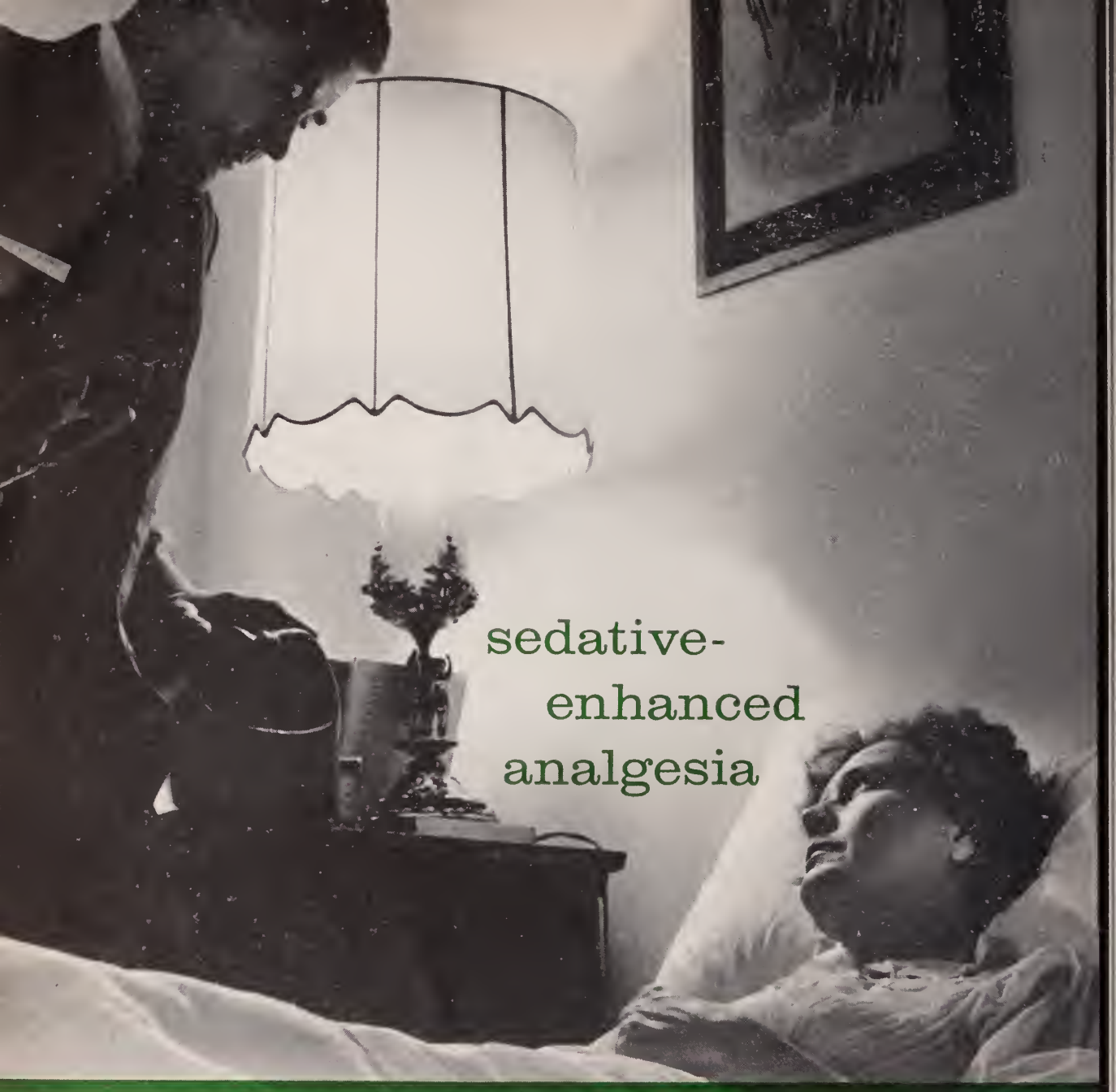
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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SAPERSTEIN, R. B.: Treatment of Acne with Long Term Continuous Abrasion. A.M.A. Archives of Derm. 81: 601, April 1960.

REES, R. B.; BENNETT, J. H.; GREENLEE, M. R.: Newer Drug Treatment in Dermatology, Cal. Med., 91:1, July 1959.

SULZBERGER, M. B. & WITTEN, V. H.: The Management of Acne Today. Med. Clinics of No. America, 43:3, May 1959.

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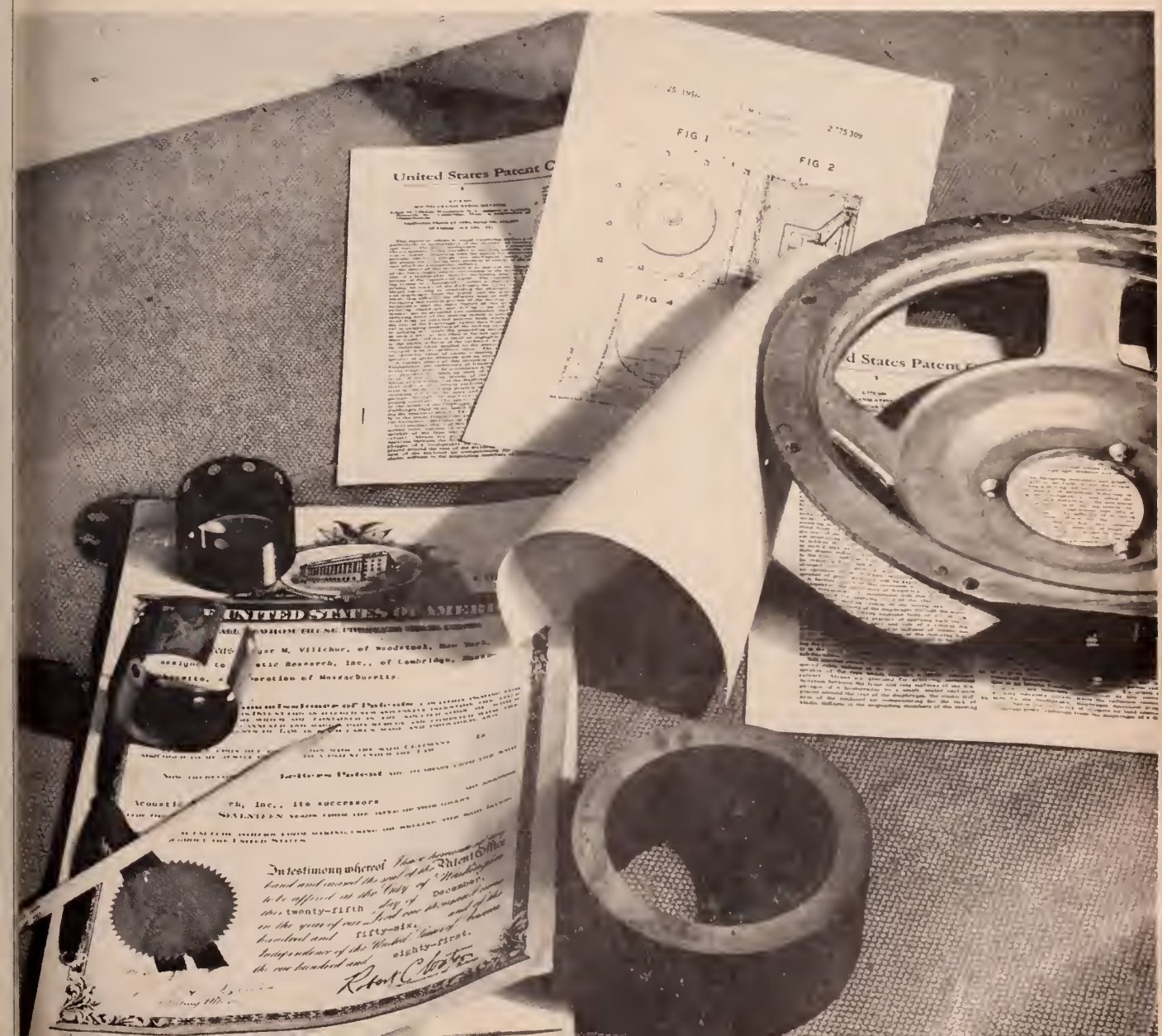
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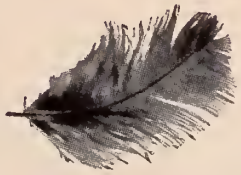
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References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy 18:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, in press. 3. Shaftel, H. E.: Clin. Med. 7:1841 (Sept.) 1960.

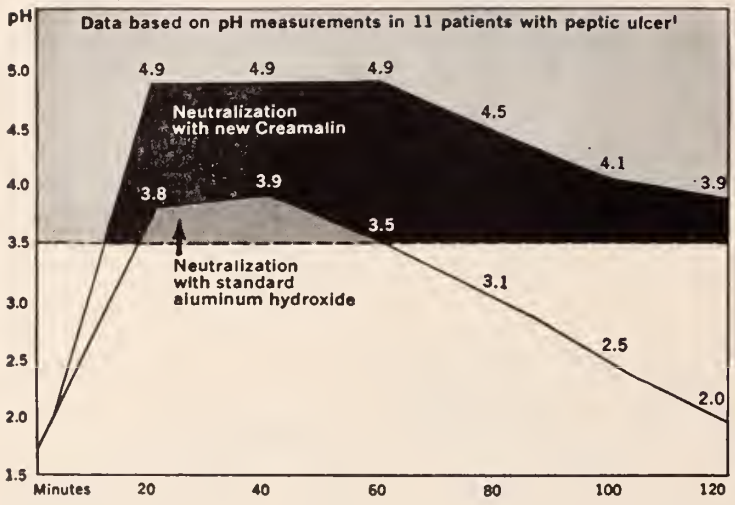
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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: J. Am. Pharm. A. (Scient. Ed.) 48:384, July, 1959.

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Editorials • • •

Confidentiality and Social Duty

Any physician may be tormented by the question of breaching a patient's confidence to bring about a social good. The Hippocratic Oath is of no help, for this simply promises that "whatever I see or hear which ought not to be noised abroad, I will keep silence thereon."* The problem is what "ought not to be noised abroad?" A threat of treason? Having a contagious disease in an infectious stage? A paranoiac's possession of a gun and determination to destroy his imaginary persecutor? Obviously, good conscience makes it necessary to violate some of these confidences. The A.M.A. *Principles of Ethics* permits revelation when necessary to protect an innocent person or when required by law. Ordinances require physicians to report gun-shot wounds, venereal disease, narcotic addicts, and so on—and the doctor certainly must conform to the law here even if it means reporting something told in confidence. As a matter of fact, the rising tide of third-party fee payments (through insurance, pension funds, and Government) has made it necessary for physicians to send diagnoses to many people outside the traditional doctor-patient dialogue. Confidentiality is not and cannot be absolute.

In New Jersey there are no "privileged communications" between physician and patient, as there are in New York; so that if he is called into court in our state, the doctor not only may, but actually must, breach the wall of confidence. However, the problem is ethical rather than legal.

An interesting case involving both law and ethics was decided recently in our neighboring state. The facts in *Clark v. Geraci* (208 N.Y.S. 2d, 564) are simply told. The doctor told the U.S. Air Force that their civilian employee was absent from work primarily because of alcoholism. The worker was fired, and sued the doctor. Here is a summary from the May 15, 1961, New York State Journal of Medicine:

*There are several translations of this phrase. The "ought not to be noised abroad" is from the version in the *Encyclopaedia Britannica*. Other translations are "that which ought not to be divulged, I will not divulge"; and (from Stedman's *Medical Dictionary*) ". . . that which ought not to be spread abroad, I will keep secret." In none of the translations is the prohibition an absolute one.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 683

VOL. 58, NO. 7 JULY, 1961

Subscriptions, $3.00 per year
Single Copies, 30 Cents

The physician had learned that the patient had taken to drink. He repeatedly treated him for respiratory infections which were the effects of the patient's alcoholism. The physician had, at the patient's request, supplied certificates to explain his absences which described the trouble as consisting of ailments, "without disclosure that many of them, such as the bronchial difficulties, were due to alcoholism."

Thereafter, the doctor alerted the patient to the fact that the Air Force had requested a letter setting forth the underlying cause of the patient's illness, because this had not been done in the prior medical certificates.

The patient sued the physician, charging that the letter was responsible for his discharge from employment by the Air Force. On the trial the patient argued that the doctor had committed malpractice in divulging a confidential communication.

The Court came to the conclusion that a cause of action would lie against a doctor who, without the patient's consent, discloses information obtained in the course of treatment. It went on to say: "While no principle of common law is violated, disclosure is reprehensible as indicated by the statutory law in this state,† accepted usage, and the Hippocratic oath; information possessed by the doctor of the illness of his patient has long been thought of as a protected professional confidence upon which every patient may rely."

After reviewing the applicable rules of law and after first observing that "had the disclosure risen to the level of a need to safeguard the security of the government or the safety of the public, as in a case of a communicable disease, it would be quite simple to find that *the doctor's duty to disclose overrode his duty to remain silent,*" the Court then went on to direct a verdict for the physician on the following grounds:

1. "In view of the prior incomplete medical certificates requested by the patient and supplied by the doctor to explain the former's absences, it may similarly be said that his right, if not *his duty to his government, to make a full disclosure of the facts superseded his duty to the patient* to remain silent."

2. The patient "not only waived the disclosure of the secret to the extent that they told of the effects of his habitual inebriation, but was aware that the certificates were true only as far as they went. Having placed the doctor in the position of telling but part of the truth, he is estopped from preventing his divulging the remainder."

3. "In addition to the legal bars to plaintiff's suit is the overwhelming proof that plaintiff's discharge was due essentially to his absences and not to the disclosure."

The decision is significant in that it calls attention to a common evil: the request for a partly true medical certificate. Many a doctor is urged to use euphemism instead of blunt truth. The Court here stated that when a patient "puts the doctor in the position of telling but part of the truth, he is estopped from preventing his divulging the remainder." Perhaps doctors should keep this on their desks and show it to the patients who want a euphemistic certificate.

Also significant is the statement that under certain circumstances "duty to government to make a full disclosure . . . supersedes the duty to the patient to remain silent." This dilemma will confront many a doctor with an agonizing conflict of loyalties. Duty to what level of government? When the patient is a policeman or school teacher does the duty to the City government supersede the duty to the patient? Is national security threatened by refusing to reveal that a stenographer in the Department of Agriculture has a salpingitis?

It would seem that the doctor cannot sit on the truth if its revelation would save a life or prevent an infection; nor if suppression of the truth would violate the law. But most of our problems are not that simple.

It's a decision which every physician has to make by himself, in communion with his God and his conscience. And whoever makes such a decision in good faith merits the support of his professional brethren.

†New York State, not New Jersey.

"When a Body Kiss a Body"

North Jersey doctors will remember Charles Craster, Newark's long-term Health Officer and his anti-baby-kissing campaign. He distributed bibs which said "Don't Kiss Me"; or "Kissing Transmits Germs." The campaign aroused much merriment and some indignation from those who felt that being opposed to kissing was Anti-American since, after all, kissing is part of the romantic tradition of America. It could stand anything but ridicule. As Zagury[1] said: "Some women blush when kissed; some call for the cops; some swoon and some swear; but the worst are those who laugh." And Holmes[2] remarked with more truth than poetry that "The sound of a kiss is not so loud as that of a cannon: but its echo lasts much longer."

Kissing is supposed to be harmless and people like Charles Craster were considered killjoys. As Robert Burns[3] (the poet, not the cigar) said: "When a body kiss a body, need a body cry?" It seems the answer might be 'yes.' This unchivalrous attack on one of America's favorite sports was launched in, of all places, the medical magazine *GP*. Here Evans[4] reported that kissing can and does transmit infectious mononucleosis. The incubation period (for the curious, the science-minded or the just plain suspicious) is 32 to 50 days. The first cynic, it seems was Hoagland[5] who did medical (and social) histories on 75 West Point cadets with infectious mononucleosis. He found that 71 of them had kissed a girl within 7 weeks before the first symptom. (The other four, we understand, were referred to the psychology laboratory for lie detector tests and to the physiologic laboratory for endocrine studies).

Evans[4] made a study at the University of Wisconsin where he is (or before he published the paper *was*) Professor of Preventive Medicine. He found that 78 per cent of the victims reported osculatory contacts within the incubation period. The controls, on the other hand (virile Wisconsin students who were in this hospital for other disorders) reported such "intimate oral activities" on a much smaller scale—only 48 per cent had a history of bussing[6] and the statisticians figured that in this case the difference between 78 and 48 per cent was significant.[7] The conclusions seem to be (a) Infectious mononucleosis is an occupational hazard of college students; (b) It also serves as a rough and ready lie detector test; (c) It is, in a way, a social disease, but one which carries no social censure.

The only safe kissing, if one wants to be strictly sanitary, would be to follow the Austrian practice. *Kuss die Hand, gnadige Frau.*

---

1. Zagury, Joseph: *Osculatio Femininarum*, Bologna, 1961.
2. Oliver, not Sherlock Holmes: (Oliver Wendell Holmes in "The Professor at the Breakfast Table").
3. Burns, Robert: 'Coming Through The Rye!" (a poem and a song).
4. Evans, Alfred S.: *GP*, February 1961.
5. Hoagland, A. J.: American Journal of The Medical Sciences, 229:262 (Feb. 1955).
6. According to our dictionary, "A buss is a rude or playful kiss." The dictionary further clarifies by quoting the following couplet from Robert Herrick. "Kissing and bussing differ both in this: we buss our wantons, but our wives, we kiss." This Robert Herrick (1591-1674) must have been quite a character. He is responsible for such phrases as "Gather ye rosebuds while ye may" and "Blest is the Bride on Whom the Sun Shines." He was a bachelor, and according to the *Encyclopaedia Britannica* "he lived at a vicarage surrounded by a family of pets, tended by a servant whose first name was Prudence." When the Puritans came to power, they ejected Herrick from his vicarage.
7. If you don't believe that this is statistically significant let us explain that the goodness of fit is good, the chi square is 10.2, the coefficient of correlation is plus five, the standard error is improbable, and the Poisson exponential variant is a non-central random. Any more argument? (We don't know what this means, either).

Board of Trustees: April 16, 1961

At its April 16, 1961 session, actions taken by the Board of Trustees included:

STUDY OF THE M'NAGHTEN RULE

The New Jersey Bar Association has appointed a special committee to study the M'-Naghten Rule, to determine what should be the future of the rule in our state. Mr. Louis Auerbacher has requested a meeting with representatives of the Society and the New Jersey Neuropsychiatric Association. After consultation with the President-Elect, Dr. Buchanan, the following committee and meeting arrangements were agreed to: committee: Dr. Buchanan, Dr. Mulligan, Dr. McCall, Mr. Backes, and Mr. Nevin. The meeting will be on June 7.

Action: This decision was approved by the Board.

MENTAL HEALTH COMMISSION

In a report from the Society's representative on the State Mental Health Commission, Dr. Richard E. Gordon, Jr., announcement was made of the availability of the Commission's report to the Governor and the Legislature. Through Dr. Gordon, copies of the report have been sent to the Officers of the Society, the Councils on Legislation and Public Health, presidents of component societies, and chairmen of county mental health committees.

STATE TUBERCULOSIS COUNCIL

Dr. John B. Fuhrmann was appointed by Dr. McCall to serve as our official representative on the State Tuberculosis Council. This action was approved by the Board.

VOLUNTARY HEALTH INSURANCE CONFERENCE

Received and noted was a report from Dr. Lloyd, who was absent, on the AMA Regional Conference on Voluntary Health Insurance and Prepayment Plans which he attended in Washington, D. C., as the official representative of the Society. "In summary," Dr. Lloyd reported, "it was an interesting exchange of ideas. The problems we have are universal—if anything, more acute elsewhere. The solutions will arrive by evolution." He further reported that the AMA will sponsor its Second National Congress on Prepaid Health Insurance early in the fall of 1961.

MAJOR MEDICAL INSURANCE

Inquiry was received from a member of the Medical Defense and Insurance Committee as to whether it would be possible to include full-time employees of the State and component societies in the major medical program, if and when it is adopted. The carrier has agreed to include such employees in the program if this is requested by the Society.

Dr. Featherston recommended that the Board request the carrier to include full-time employees of State and component societies as eligible participants in the major medical program, if and when it is accepted, such employees to pay their own premiums.

Action: The recommendation was approved.

PROFESSIONAL LIABILITY INSURANCE

Dr. Featherston reported that as of March 31, 1961, only 23 per cent of the insurable members have availed themselves of the coverage available under the American Mutual program. County participation ranges from none to 42 per cent. From the number of inquiries about liability insurance, it is evident that many members have not read the literature sent out by American Mutual announcing the new program.

Action: It was agreed that the membership again be circularized, over the name of the committee, about the availability of the liability insurance through American Mutual; and that this be a short communication on Medical Society stationery. It was also agreed that the component societies be urged to have this program discussed at local hospital staff meetings.

COUNCIL ON PUBLIC HEALTH

MENTAL HEALTH

The following action of the Council on Public Health, taken at its meeting on April 5, 1961, was referred to the Board of Trustees.

The Special Committee on Mental Health recommended that a "Statement on Relations of Medicine and Psychology" be published in THE JOURNAL for the information of the membership. The committee feels that the differences in the fields of psychiatry, psychology, and social work are not generally understood by the majority of physicians. The statement has been published previously in the official Journals of the American Medical Association, American Psychiatric Association, and American Psychoanalytic Association between 1954 and 1957; no change has been made in it since then. The council approved the recommendation of the special committee.

Action: This decision was approved and the item will be published in THE JOURNAL.

CHILD HEALTH

The Special Committee on Child Health proposed modifications to the State law and Board of Education ruling concerning school health problems—working paper examinations, mental health, and athletic examinations. The proposals concerning working paper examinations and mental health were approved by the council.

Action: The resolution on working paper examinations was referred to the Council on Legislation for study and report.

Action: The two resolutions concerning mental health of school children were referred to the Council on Legislation for study and report.

Action: The following council recommendation was approved:

The proposal concerning athletic examinations would permit family physicians to give the required physical examination to a candidate for a school athletic squad or team. The present State Board of Education ruling provides that the examination shall be given "by the medical inspector or team doctor." This proposal was disapproved by the council for the following reasons: (1) the examination as given by a family physician might be inadequate for the purposes intended; and (2) inasmuch as the requirement of a physical examination is a ruling of the State Board of Education, the Board itself should make provision for such examinations.

REHABILITATION

The Special Committee on Rehabilitation has investigated all possible sources for obtaining financial aid toward the compilation of a Directory of Rehabilitation Facilities in the State of New Jersey, and no aid is available.

The committee is submitting the following recommendations to the House of Delegates with the approval of the Council on Public Health:

1. That the House of Delegates authorize the appropriation of $10,000 to the Special Committee on Rehabilitation for use in defraying the cost of full-time personnel required to compile a Directory of Rehabilitation Facilities in the State of New Jersey. (Note: The 1960 House of Delegates approved the report of the committee which stated "if funds are not available from this source—Office of Vocational Rehabilitation—then the committee intends to recommend that the project be undertaken by The Medical Society of New Jersey.")

The Board noted that, at its December meeting, it had tabled a request for funds "for obtaining the services of a full-time Rehabilitation Service Worker" until an estimate of cost was received.

Action: The recommendation, appropriating $10,000, was disapproved.

2. That the Committee on Rehabilitation in each component society be instructed to cooperate in collecting the desired material and information for its respective county.

Action: That the word "instructed" be changed to "requested," and the amended recommendation is then approved.

CONSERVATION OF VISION

The Special Committee on the Conservation of Vision recommended that the 1961 Eye Health Screening Program be conducted during the week of September 25, 1961. The council approved the recommendation.

Action: This was approved.

The special committee presented the following *recommendations*:

1. The committee recommends, as it has in other years, continuing efforts to maintain in each component society active committees for the care of chronically ill and aging. To act as coordinating centers for all programs concerning the chronically ill and aging, these committees should assemble information as to available facilities and the facilities that are needed, and should aid in stimulating the development of needed facilities. They should aid in the development of information and referral centers. (Recommendation No. 1 was approved by the council.)

Action: This is approved.

2. The citizens of New Jersey look to the medical profession for leadership in the health field and we believe that there is an urgent need for greater community effort, under medical direction, in extending and improving rehabilitation and restorative services throughout the State. We recommend, therefore, that the component societies direct their attention toward bringing about a more effective community program of rehabilitation and restoration for the aging and the chronically ill.

The council was of the opinion that recommendation No. 2 might be a duplication of effort in this area by the special committee and the Committee on Rehabilitation. The council approved the recommendation with a further recommendation that the two committees continue to work closely together in this field.

Action: The Board took no action on recommendation No. 2, but indicated its general approval of the opinion of the council on the subject.

3. The committee recommends for adoption by The Medical Society of New Jersey, as an expression of policy, the following outline for a Program of Medical Care for the Aged. (Recommendation No. 3 approved by the council.)

1) Re-adoption of realistic attitude toward the aging by encouraging full or partial employment of individuals according to their capabilities and without regard to mere calendar age.

2) Assignment of responsibility for financing of health care in the following order: the individual; the family; local voluntary agencies; local, county, state, and federal government . . . each to take over only when the precedent agent of responsibility cannot meet the need.

3) Promotion of health maintenance through significant constructive activity, proper diet, intelligent exercise and living habits, regular physical checkups, and early detection of disease.

4) Utilization of all restorative and rehabilitative services for the return of the incapacitated to self-care and independent living.

5) Development of community activities for those older people incapable of independent constructive activity.

6) Extension of private voluntary prepayment insurance to effect adequate economical coverage of the aging citizens.

7) Establishment of tax-supported programs—under the Kerr Mills Bill—administered locally, with benefits available to people according to their demonstrated needs.

8) Encouragement of facilities for the care of those incapacitated aging citizens for whom family care is not possible.

9) Dissipation of the concepts that aging is a handicap and the aged a problem, and substitution instead of the realization that aging is a natural process and that the aged are first-class citizens who through their past and present contributions enlarge the general good.

Action: Recommendation No. 3 was approved.

4. The committee considered the development of a Home Care Program, as presented by Dr. Curtis Culp of the State Department of Institutions and Agencies, and recommends the adoption of this program, in principle, as a policy of The Medical Society of New Jersey.

Members of the council were of the opinion that the program should not be officially approved until such time as the results of the pilot study in Hunterdon County are available. The council adopted a motion that approval in principle of *a* home care program be given, and that official approval of the proposed home care program as now in opera-

tion in Hunterdon County be withheld until the results of the pilot study become available.

Action: The Board approved the action of the council on No. 4.

The council has a continuing problem: a method of expediting the voluminous business items without being hampered by lengthy special committee reports only brought to the council's attention on the day of the meeting. Some of the chairmen of the special committees are extremely conscientious and diligent; others have not responded to the appointment of a liaison member of the council to their committee urging them to meet in ample time to submit written reports in advance. The council now asks that the Board of Trustees specifically charge the chairmen of the special committees to meet on definite dates at least two weeks prior to the quarterly council meetings, so as to provide ample time for the Executive Offices to reproduce the minutes for appropriate action by the council.

Action: The council's recommendation is approved.

AMEF CONTRIBUTION TO SETON HALL

Received from AMEF was a check in the amount of $7,082 for presentation to the Dean of Seton Hall College of Medicine by an Officer of the Medical Society "with attendant publicity."

Action: The check will be presented at the organization meeting of the College Board of Trustees on May 10, 1961, by Dr. Mulligan as chairman of this Board and as New Jersey Chairman for AMEF.

MSP DISPUTED BILLS COMMITTEE

Dr. Bowers presented a suggestion from his committee—a suggestion that has MSP approval. Under this proposal, instead of having five regular members and five alternates, the committee will consist of ten members. Four would constitute a quorum.

Action: The Board will suggest to the incoming administration, that two members be appointed from each District, with no division between alternates and regular members; and that four be a quorum.

LEGISLATION

The recommendations contained in the following report were submitted to the Board as informational. These are offered for the guidance of the Board, as embodying the attitudes of the three members of the council who were present at the meeting.

1. *"Good Samaritan" Proposed Legislation*: The council unanimously approved the proposed draft submitted by the Legislative Analyst, in support of the resolution from Essex County requesting the encouragement of legislation "to protect New Jersey physicians rendering first aid in emergency situations."

The council further recommended that the Medical Society develop as much support and sponsorship among paramedical groups, and then introduce this legislation at an appropriate time. In discussing this legislation, the council agreed that its introduction should take precedence over that prohibiting entertainment hypnosis.

Action: This proposed legislation is approved.

2. *Current State Legislation*: The council took the following actions concerning legislation of medical interest.

S-128 *Farley*—To create a presumption that certain respiratory diseases of police and firemen were received in the line of duty. *Disapproval* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

A-430 *Kijewski, Brady*—To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approval.*

A-441 *Meloni, Werner*—To amend the act regulating nursing; reduces the age for professional nurse candidates from 20 years to 18 years, and raises fees for examinations and registrations. *Approval.*

Action: The recommended positions on S-128, A-430, and A-441 were approved.

S-111 *Farley*—To provide for the establishment of nonprofit dental service corporations. *No action.* The council recommends this position in view of the fact that as of the present time the Medical Society has not been requested by the New Jersey Dental Society to take any indicated position as regards this measure.

Action: The recommended position on S-111 was approved.

S-150 *Stout*—To provide that services performed by a duly registered bioanalytical la-

boratory are within the scope of medical service plans.

Discussion concerning this bill was detailed and extended. The members concluded that there were three alternatives of action possible.

1. To accept and approve this proposed supplement to the Enabling Act;
2. To recommend the discontinuance of Rider "A";
3. To ask the Plan to rule that hereafter it will pay for compensable services to lay-directed bioanalytical laboratories rendered to eligible subscribers of Rider "A" on the same basis as it now pays nonparticipating physicians, by sending remuneration to the subscriber to be remitted to the lay director.

   This same principle might also be applied to the dental-oral surgeons, thus eliminating the necessity of embracing or supporting a separate supplement to the Enabling Act.

The council was in unanimous agreement with alternative No. 3.

Action: Alternative No. 3 was approved in principle but not be moved for definite action until after consultation with MSP.

A-422 D'*Aloia*—To include within the definition of narcotic drugs any drugs determined by the Health Commissioner to have addiction "liability" similar to morphine or cocaine. *Approval.*

Action: The recommended position on A-422 was approved.

A-488 *Brady*—To make available for free distribution copies of questions previously used in examinations conducted by the State Board of Medical Examiners. *No action.*

Dr. Buchanan informed the Board that 25 copies of all examinations are filed with the State Library in Trenton. These are available to those who want to take the time to review them. Most requests for copies come from foreign graduates, not from American and Canadian graduates. The State Board of Medical Examiners is actively opposed to A-488. Letters have been sent to all legislators announcing the State Board's opposition.

Action: That this Society cooperate with the State Board of Medical Examiners in opposing the free distribution of these examination questions, for the reason that copies are available in the State Library and free distribution would be a burden on the taxpayers. Accordingly, A-488 was *Disapproved.*

A-497 *Sarcone, Lindeman, LaMorte, Stiles, Tate, Stamler*—To provide that certain notices of hospital and medical liens may be filed in the county clerk's office within 90 days after the first date of treatment. *Approval.*

Action: The recommended position on A-497 was approved.

A-501 *Hughes*—To provide for blood grouping tests and to restrict the use of arrest warrants in bastardy proceedings. *No action.*

Action: The recommended position on A-501 was approved.

A-502 *Wilson, Hughes, Crabiel, Tanzman, Doren, Beadleston, Barkalow*—To restrict driver examination tests following a motor vehicle accident to cases where a driver was held to have contributed to the accident. *Action deferred* . . . pending information from the Division of Motor Vehicles concerning their opinion in conjunction with this legislation.

Action: The recommended position on A-502 was approved.

A-511 *Hughes, Meloni, Frederick, Werner, Koenig, Madden, Krant, Musto, LaMorte, Tate, Sarcone, McGowan*—To amend the Radiation Protection Act of 1950 to more clearly define the regulatory department's powers. *Action deferred* . . . pending information from the New Jersey Radiological Society concerning their views on this legislation.

Action: The recommended position on A-511 was approved.

A-513 *Werner, Davis, Marut, Volpe*—To require the use of humane methods in the slaughter and preparation for slaughter of livestock. *No action.*

Action: The recommended position on A-513 was approved.

A-521 *Brady, Davis*—To amend the act regulating the practice of optometry to permit the use of the words "specializing in contact lenses" on the professional card of optometrists. *Disapproval, with active opposition if bill moves* . . . because the Board of Trustees (meeting on 3/19/61) approved a report of the Special Committee on Conserva-

tion of Vision which viewed the fitting of contact lenses as a procedure proper to the practice of medicine. Moreover, the council opposes this legislation as untimely, inasmuch as presently the Attorney General is preparing an opinion concerning the legality of the fitting of contact lenses by optometrists. It would seem that until the Attorney General's opinion has been issued, no legislation in this area should properly be introduced or moved.

Dr. Buchanan reported that the Attorney General had informed the State Board of Medical Examiners that he would release his opinion shortly concerning the legality of the fitting of contact lenses by optometrists. He feels that physicians should fit contact lenses, but that under the present law it is within the purview of optometrists to do so. It is the feeling of the Attorney General that medicine should bring out specific legislation to prevent optometrists doing this, and he encourages medicine to prepare a bill to forbid this.

Action: The recommended position on A-521 was approved.

Action: The Council on Legislation is advised to consider an amendment to the Medical Practice Act and/or the Optometric Act which would preclude optometrists' prescribing and fitting contact lenses.

A-531 *Hughes, Frederick, Koenig*—To make several amendments to the act regulating the practice of ophthalmic dispensing. *Action deferred* . . . pending opinion concerning this legislation from the Society's Special Committee on the Conservation of Vision.

Action: The recommended position on A-531 was approved.

PUBLIC RELATIONS

At its meeting on April 9, 1961, the Council on Public Relations considered a communication from the Middlesex County Medical Society which the council referred to the Board of Trustees. The county society recorded its unanimous action favoring the selection of men of experience in political and professional debating by the State Society and the AMA to represent medicine in national and state radio and television programs. It was the consensus of the county society that in recent programs the physician-speakers did poorly against their opponents. The Society was requested to relate this action of the county to the A.M.A.

Action: An appropriate communication will be sent to the AMA.

TRAFFIC SAFETY

The Special Committee on Traffic Safety has met several times with representatives of the Division of Motor Vehicles. The latter have stated that they have no physicians on their staff, and felt the need of a panel of impartial medical specialists to whom a questionable applicant or driver could reliably be referred for determination, on the basis of dependable scientific evidence, as to his capability to operate a motor vehicle without danger to himself or others. The Division would pay the members of such a panel on a *per diem* basis. It is felt that whatever plan is eventually adopted should be under the direction and supervision of one physician who has close liaison with the Division.

Mr. Nevin suggested that the chairman of the Special Committee on Traffic Safety, Dr. Maldeis, be designated as the Society's official liaison representative with the State Division of Motor Vehicles.

Action: That the suggestion of the Executive Officer be approved.

OCCUPATIONAL HEALTH

The recommendation of the Special Committee on Industrial Health that its name be changed to "Occupational Health," received and tabled by the Board at its March meeting, was taken from the table.

Dr. Buchanan has made inquiries among industrial physicians around the State, and to the Industrial Medical Association of New Jersey, and none are in accord with the recommendation. They all feel that the problems of industrial health are sufficient to retain a special committee in this field, and that industrial health should not be grouped with other occupations. He recommended that the change not be made.

Action: The request of the special committee for a change in name is not concurred in.

NEW HOSPITALS

A communication from the Board of St. Joseph's Hospital, Paterson, voiced concern over the activity in the northeast area of the State toward establishment of new hospitals

which that Board feels may not be in the best interest of the community. The activity seems to arise from the lack of beds in the larger hospitals, making it necessary to delay admission for elective procedures as much as several weeks. However, that Board feels that greater effort should be directed toward expansion of existing facilities rather than toward setting up new hospitals. The Medical Board asked if there are any means existing to control the location of these institutions, or is it necessary to attempt to institute legislation to effect this end? This situation is acute in Passaic and Bergen Counties, and, it contends, needs to be faced squarely and honestly now.

Action: A reply will be made that this Board of Trustees has no authority as to the establishment of hospitals, and that this belongs within the authority of the Legislature to amend the law governing the Hospital Licensing Board in the State Department of Institutions and Agencies.

N. J. Physicians Share Increasingly in Blue Shield Remittances

Annual payments to physicians by Medical-Surgical Plan of New Jersey (Blue Shield) for services rendered to members increased between 1950 and 1960 at almost one-and-a-half times the rate of gain reported for nationwide Blue Shield payments, it was announced today by Dr. Royal A. Schaaf, New Jersey Blue Shield president.

The National Association of Blue Shield Plans announced this week that payments totaling more than $731 million were made to physicians by the 74 nationwide Blue Shield Plans in 1960. This represented an increase of 530 per cent over the 1950 figure of approximately $116 million. New Jersey Blue Shield payments to physicians in 1960 were $31.5 million, a rise of 751 per cent over the $3.7 million paid in 1950.

The New Jersey Plan's 1960 payments, made on behalf of subscribers representing an enrollment of over 2,000,000 members, represented an all-time high for one year, as did the national figures. Operating expenses of New Jersey Blue Shield were less than 9 per cent of total income for the year, while the national average of administrative expenses was under 10 per cent.

In the national report John W. Castellucci, executive vice-president of the national association, said, "The impressive increase in payments to the medical profession over the years on behalf of Blue Shield members clearly reflects the ability of these medical-surgical plans to develop realistic and flexible programs in order to keep pace with the tremendous advances in our medical care system. At the same time, our Plans have annually expended a lesser percentage of their income dollar to administrative expenses in the face of spiralling inflation and the commensurate cost of doing business."

Do You Have a Paper for the Next Annual Meeting?

The Committee on Annual Meeting and various section chairmen want the program to represent real membership participation. So, if you have any ideas about the content of the program for any section, notify the Executive Offices. If you have a paper of your own, send the data to the Annual Meeting Committee, care of Executive Offices, The Medical Society of New Jersey, Box 904, Trenton 5, N. J. The committee will want to know the title and subject of the paper, the time you would need to present it, whether you will need lantern slide, moving picture, or blackboard facilities, and in what Section the presentation would seem most appropriate.

195th Annual Meeting — May 13-17, 1961
Haddon Hall, Atlantic City

Official Attendance

County	Delegates	Members	Total
Atlantic	11	79	90
Bergen	41	29	70
Burlington	6	17	23
Camden	22	44	66
Cape May	3	8	11
Cumberland	6	5	11
Essex	80	146	226
Gloucester	5	7	12
Hudson	34	22	56
Hunterdon	3	5	8
Mercer	24	51	75
Middlesex	19	30	49
Monmouth	21	49	70
Morris	16	27	43
Ocean	4	13	17
Passaic	33	31	64
Salem	3	9	12
Somerset	6	9	15
Sussex	3	3	6
Union	34	44	78
Warren	2	8	10
Fellows and Officers	16	..	16
	392	636	1,028
Physician Guests			73
Physician Exhibitors			33
TOTAL PHYSICIAN REGISTRATION			1,134
Auxiliary—Members, 385; Guests, 41			426
Visitors			369
Exhibitors			320
TOTAL REGISTRATION			2,249

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1961	1,134	1,115	2,249
1960*	1,254	1,307	2,561
1959	1,124	932	2,056
1958	1,193	950	2,143
1957	1,202	909	2,111

* highest registration on record.

1961 House of Delegates

Registration and Attendance

The following is a report on the registration and attendance of the members of the House of Delegates at the sessions of the 195th Annual Meeting, Haddon Hall, Atlantic City, May 13, 14, and 15, 1961:

Total Possible Delegation	439	—	100. %
Total Registered Delegates	392	—	89.3%

Attendance at Sessions:

		% of Possible Delegation	% of Registered Delegation
First Session	(330)	75.2*	84.2*
Second Session	(366)	83.4	93.4
Third Session	(349)	79.5	89.0
Average	(348)	79.3	88.8**

*—highest on record
**—same as 1960
All other percentages were higher in 1960

	Delegation	Registered	1st Sess. 5-13-61	2nd Sess. 5-14-61	3rd Sess. 5-15-61
Atlantic	11	11	10	10	11
Bergen	42	41	35	40	40
Burlington	6	6	6	6	6
Camden	22	22	20	20	22
Cape May	3	3	2	2	1
Cumberland	6	6	6	5	5
Essex	99	80	55	71	61
Gloucester	5	5	5	4	5
Hudson	43	34	28	33	31
Hunterdon	3	3	3	3	3
Mercer	27	24	22	21	22
Middlesex	20	19	18	19	17
Monmouth	21	21	20	21	20
Morris	17	16	16	16	16
Ocean	5	4	4	4	4
Passaic	35	33	26	32	28
Salem	3	3	3	3	3
Somerset	7	6	6	6	6
Sussex	3	3	3	3	3
Union	38	34	26	32	30
Warren	3	2	2	2	2
Fellows and Officers	19	16	14	13	13
TOTAL	439	392	330	366	349

195th Annual Meeting

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigation, judged on the basis of originality and excellence of presentation:

First Place: Angioma in Bone

Daniel Wilner, M.D., Atlantic City; and Robert S. Sherman, M.D., Memorial Center for Cancer and Allied Diseases, New York, N. Y.

Second Place: Intravenous Arteriography

Robert Alan Keisman, M.D., Hunter S. Neal, M.D., and Melvin M. Meyers, M.D., Lankenau Hospital, Philadelphia, Pa.

Honorable Mention: Profound Hypothermia in Cardiovascular Surgery

John Y. Templeton, III, M.D., and Ralph Lev, M.D., Jefferson Medical College Hospital, Philadelphia, Pa.; and St. Peter's General Hospital, New Brunswick

Class II—New Jersey Exhibitors:

First Place: Open Correction of Mitral Stenosis and Insufficiency

Theodore R. Keith, M.D., Dryden P. Morse, M.D., Michael Ramundo, M.D., Pasquale Racaniello, M.D., Daniel Downing, M.D., F. Albert Graeter, M.D., William Cantwell, M.D., Nathan Nussbaum, M.D., and Lawrence E. Batlan, M.D., Passaic General Hospital, Passaic

Second Place: Cineangiocardiography

John W. Marquis, M.D., John H. Donnelly, M.D., E. Johnson, M.D., Robert Porcelinko, M.D., J. Mathias, M.D., Peter P. Poulos, M.D., and Arthur Bernstein, M.D., Heart Institute, United Hospitals of Newark, Newark

Honorable Mention: Interstitial Fibrosis of the Lung in Rheumatic Heart Disease

Sylvan E. Moolten, M.D., Mikio Makino, M.D., and A. Marshall Smith, M.D., Middlesex General Hospital, New Brunswick

Doctor's Hospital Patients Not Blue Cross Eligible

Subscribers to New Jersey Blue Cross who become patients in Doctor's Hospital, 170 East End Avenue, New York City, are not eligible for Blue Cross service benefits. Doctor's Hospital does not participate in the Inter-Plan Service Benefit Bank of Blue Cross Plans. As a result, subscribers to New Jersey Blue Cross who are hospitalized there receive, instead, the benefits provided for admissions to Non-Contracting Hospitals: Up to a maximum of $15 a day toward the total charges made by the hospital.

The reminder has been issued because of the volume of admissions to Doctor's Hospital reported by New Jersey Blue Cross.

The Inter-Plan Service Benefit Bank is a reciprocal program organized ten years ago by the American Hospital Association. It assures that any Blue Cross subscriber hospitalized away from his own area will receive the service benefits of the local Blue Cross Plan prevailing at the place of hospitalization, provided the hospital where he is admitted participates in the Inter-Plan program.

In effect, the patient is treated temporarily as a local Blue Cross subscriber. The number of days authorized for service benefits is in accord with the provisions of his own Blue Cross Plan. Such a patient is charged only for any services not provided in the local Blue Cross Plan Contract.

Obituaries • • •

DR. ALEXANDER P. DEMIDOV

Dr. Alexander P. Demidov, Lacey Township's only physician, died on May 18 at his home. Born in Russia in 1894, Dr. Demidov received his M.D. at the Imperial University of Moscow in 1916. After military service towards the end of World War I, he entered the growing field of pathology, eventually becoming Assistant Professor of Pathology. In 1930 he came to the United States. Pending validation of his European credentials, he studied economics and sociology, earning a master's degree in economics at New York University. During World War II, he served as a Government economics analyst. At the end of the war, he did graduate work in internal medicine and then entered private practice. The officials of Lacey Township invited Dr. Demidov to come there and serve as township health officer as well as do general medical practice.

DR. CHARLES LITTWIN

On May 13, death came to Dr. Charles Littwin, who for almost half a century had been serving the people of Bergen County. Born in Connecticut in 1893, Dr. Littwin received his M.D. at Fordham in 1918. He immediately entered the Navy where he served during World War I and then came to New Jersey to practice. He became increasingly interested in ophthalmology and was one of the first New Jersey doctors to earn the diploma of that Board in 1932. Seven years later he was certified in otolaryngology.

Dr. Littwin was active in the affairs of the Bergen County Medical Society and had a tour of duty as president of that organization. He was a Life Fellow of the American Academy of Ophthalmology and of the New York Academy of Medicine.

Dr. Littwin was active in civic affairs and director of the Edgewater National Bank. He headed the Ear, Nose and Throat Department of the Pascack Valley Hospital and was attending otolaryngologist at several hospitals in Bergen County.

DR. JACK L. VOSS

On May 1, Dr. Jack Landon Voss, a Morristown surgeon, died of a coronary attack. Born in Newark in 1907, he received his M.D. in 1932 at the College of Physicians and Surgeons, Columbia University. After interning at the Morristown Memorial Hospital, he established his home and office in Morris County. He was lieutenant colonel in the medical corps of the Army during World War II. Dr. Voss had a term as president of the Morris County Society, and was secretary of the surgical department of the Memorial Hospital at the time of his death. A Fellow of the American College of Surgeons, he limited his practice to general surgery.

DR. RALPH W. WALTON

On April 23 a heart attack took the life of Dr. Ralph W. Walton of Montclair. Born in upstate New York in 1887, Dr. Walton was graduated in 1924 from the medical school of Harvard University. After interning at Massachusetts General Hospital, he came to New Jersey to do family practice, and he served the people of west Essex for more than a quarter of a century. Dr. Walton was on the medical staffs of Orange Hospital Center, Mountainside Hospital and Montclair Community Hospital. He was an active member of the Boylston Society.

DR. CHARLES WARREN

One of New Jersey's civic and medical leaders, Dr. Charles B. Warren, died on May 19, at a hospital in Ogdensburg, New York. Born in Johnstown, New York, in 1873, he was graduated in 1909 from the medical school of the University of Vermont. He then moved to New Jersey where he served the people of Bergen County as a family doctor for half a century. He was prominent in civic affairs, and had two terms as mayor of Bergenfield. He was a director of the Bergen National Bank, police surgeon, and for two decades was one of the senior surgeons for the New York Central Railroad.

Announcements

Fitkin Day: July 22

All New Jersey doctors are invited to attend a pleasant interlude at the shore combined with a day of medical learning. The meeting will be in the air-conditioned Ford Auditorium of the Fitkin Memorial Hospital, Saturday, July 22, starting at 9:15 a.m. The first paper is called "Trade School v. Artful Gynecology." The next is on extracranial vascular disease. There will be a paper on rehabilitation in children and a closing report on the special biologic problems of man in space. Luncheon is available if you notify the chairman in advance that you will be there. For details and registration write to Dr. Louis F. Albright, 601 Grand Avenue in Asbury Park. The Fitkin Memorial Hospital is in Neptune, between Asbury Park and Bradley Beach.

Psychosomatic Medicine

A graduate course in psychosomatic medicine at a $40 fee is available in Philadelphia under the auspices of Temple University. The program starts on October 4, 1961. For details, write to Psychosomatic Department, Temple University Medical Center, Ontario Street at North Broad Street, Philadelphia 40, Penna.

Medulloblastoma Study

The National Cancer Institute is studying the management of medulloblastoma. If you have any such patients, communicate with Dr. Myron Karon, General Medicine Branch, National Cancer Institute at Bethesda 14, Maryland.

Diet Service in Camden County

A diet counseling service in Camden County now provides guidance for patients on special diets under medical supervision.

The diet counselor gives consideration to the patient's social and economic situation as well as therapeutic needs. This requires special knowledge and time spent in conference with the patient or some member of his family. This service is offered on the physician's written prescription, especially for patients in the following categories: diabetes, obesity, cardiovascular diseases, prenatal.

Physicians interested in this should communicate with Mrs. Edna H. Hess, Nutrition Diet Service, American Red Cross, 312 Cooper Street, Camden (Telephone: EMerson 5-7100).

Diet counseling may be given on an individual or group basis. The *New Jersey Diet Manual* is used as a basis for patient instruction. Communities interested in setting up such a service should get in touch with the Nutrition Program, New Jersey Department of Health, State House, Trenton 25.

Cancer Colloquium

A two-day session on "total care of the cancer patient" is announced for October 23 and 24 at the Biltmore Hotel in New York City. Dr. I. S. Ravdin will be chairman of the Monday morning session, while Dr. Murray Copeland of the University of Texas will moderate the afternoon meeting. On Tuesday, Drs. J. S. Hirschboeck and Warren H. Cole will preside. All aspects of care—surgical, pharmacological, psychological, medical, and even spiritual will be discussed. For detailed program, write to American Cancer Society at 521 West 57 Street, New York 19, N. Y.

County Society Reports • • •

Gloucester

The Woodbury Country Club was the scene of the May 18th meeting of the *Gloucester County Medical Society*. The program featured Dr. Abraham Ornsteen, Emeritus Professor of Psychiatry at the University of Pennsylvania, who spoke on "People in distress, in quandaries, and in flight." The lecture was highlighted by the playback of recorded interviews.

The Society then elected its 1961-1962 officers: President—R. T. DePersia, Secretary—R. P. Gotchel, Vice-President—F. M. Brower, Treasurer—G. R. Booth, Historian and Reporter—D. M. Rogers, Executive Secretary—M. F. Chew. Delegates—A. Guy Campo, J. G. Kehler, T. F. Flynn, C. I. Ulmer, and William Beall; *Alternates*—D. B. Weems, R. D. DePersia, F. M. Brower, S. T. Camp, and D. M. Rogers. Nominating Committee to State Society—A. Guy Campo; C. I. Ulmer, Alternate. Censors—William Beall, F. G. Wandall, and T. F. Flynn. Trustees—H. W. Wright, S. T. Camp, and C. I. Ulmer.

Applications for membership from Doctors Rita Mariotti, Gaston Trigos and Ian Guanwardene were read.

Dr. Camp reported that Dr. Collins had been re-elected as a Trustee of The Medical Society of New Jersey and that Dr. Patterson had been elected a delegate to the AMA.

Dr. O'Connor was welcomed as an Associate member of the Society.

Dr. Flynn closed the business session by thanking his officers, trustees, and committees for their help during his term of office. Dr. DePersia, the newly elected president, in turn presented Dr. Flynn with an engraved gavel.

An enjoyable collation followed.

WILLIAM D. KEHLER, M.D.

Reporter

Mercer

The *Mercer County Component Medical Society* met May 10 at the Trenton Country Club. The speaker of the evening, Dr. John C. Krantz, Jr., Professor of Pharmacology and Chemistry at the University of Maryland, presented a film—"Drug Addiction—A Medical Hazard." A revealing exposition was given of the pressures on medical practitioners to work beyond normal capacities. The lack of normal family relationships also produced tensions and made relief through drug addiction a potential threat to all physicians caught in this vicious cycle.

The Society nominated Leonard L. Friedmann, M.D. for the Golden Merit Award, presented by the State Society.

Peter J. Warter, M.D., out-going President, was extended the deep thanks of the Society for his successful administration and the new officers for the coming year assumed office. They are:

President—Walter R. Peterson, M.D.; Vice-President—Herbert M. Wolff, M.D.; Secretary-Reporter—Joseph J. Kline, M.D.; Treasurer—Daniel E. Boyle, M.D.

The Society approved a resolution urging The Medical Society of New Jersey to investigate the possibilities of permitting physicians to establish corporations or associations in the State of New Jersey, so they might set aside monies before taxes in pension or retirement funds. This has been approved by societies in other states and accepted by the Internal Revenue Service. The Mercer County Component Medical Society feels that our membership should be considered for such plans. The House of Delegates approved this resolution at the State Meeting.

The Society approved a gift to Mrs. Floyd D. Gindhart, a member of the Woman's Auxiliary to the Mercer County Component Medical Society, who is the in-coming President of the Woman's Auxiliary to The Medical Society of New Jersey.

JOSEPH J. KLINE, M.D.

Reporter

Middlesex

The *Middlesex County Medical Society*, under the chairmanship of Dr. Stanley A. Gadek, held its regular meeting at Roosevelt Hospital, Metuchen, on May 24 at 9:00 p.m. On recommendation of the Judicial Medical Ethics Committee (Dr. B. F. Slobodien, Chairman) the following applications were approved: for election to Regular membership from two years of Associate membership for Drs. John Guy Falcone, New Brunswick; Belardino Lupini, Carteret; and to Regular membership by transfer from the Baltimore Medical Society: Dr. Francis M. Clarke, Jr., New Brunswick.

The membership voted to continue the emergency numbers listing in the yellow pages of the Telephone Directory.

Dr. Irving Kane of the Program Committee of the Medical Radio Institute of New York showed an interesting medical newsreel pilot film on "A New Idea in Graduate Education."

Drs. Merle Davis and Donald Reisfield of New Brunswick discussed medical economics as seen in

United Mine Workers Clinics and in a socialized system in Europe. They reported that patients felt they were getting something for nothing but that actually they were getting inefficient and second-rate care at a high cost.

A collation was then served.

THOMAS I. STEINBERG, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on April 18 at 9:00 p.m. at the Medical Society Building. The president, Dr. F. Albert Graeter, presided.

Drs. Ernest Cohen of Pompton Plains and M. Robert Levy of Paterson were elected to Active membership by transfer.

A resolution on the death of Dr. Joseph N. Roy was read and adopted.

Dr. Harry Wolfson, Chairman of the Building Trustees gave a report on his committee's activities. The report included recommendations for an addition to our present building.

Dr. Sandor Levinsohn, Chairman of the Constitution and By-Laws Committee read a proposed amendment to the Constitution. This will be published in the May *Bulletin* and voted on at the next meeting.

Dr. Edward Wolfson, Program Chairman, advised the members of the next meeting which will feature a panel discussion on "Disability Evaluation in Compensation Cases," with participants from the Medical Society and the Bar Association. Dr. Wolfson then introduced the guest speaker, Mr. Bradbury K. Thurlow, a stock analyst, who spoke on "The Present Profit Potentials in the Stock Market." This exceptionally interesting subject was enthusiastically received by the 100 members attending the meeting.

At the conclusion of the program, a collation was served.

The annual meeting of the *Passaic County Medical Society* was held on May 23 at the Alexander Hamilton Hotel with the Passaic County Bar Association as guests of the Medical Society. Dr. F. Albert Graeter, president, welcomed those attending.

The following were elected to membership: Active by transfer—Drs. Blanka Sender of Paterson and Siegbert Bornstein of Pompton Plains; Courtesy to Active—Jerome Torsney of Clifton.

Dr. Graeter reported on several items of special interest to our members in connection with the activities of the State Convention in Atlantic City.

He then read the following amendment to the Constitution and By-Laws which was unanimously approved by the members.

ARTICLE VII, Section 4. Delete: "Associate members shall pay only the cost assessed by The Medical Society of New Jersey for the annual subscription to the JOURNAL."

Add: "Associate members shall pay one-third the amount of dues fixed for Active members by the Society at its October meeting."

The president called upon Dr. Theodore K. Graham of the Nominating Committee who read the report as follows:

President—David B. Levine. First vice-president—Francis R. Meyers, Second vice-president—Marion F. Kaletkowski, Secretary—Irving Chrisman, Treasurer—Frank B. Vanderbeek, Assistant Treasurer—James A. Rogers, Reporter—Alex E. Schefrin, Board of Censors—F. Albert Graeter, Building Trustee—Leon E. DeYoe.

Dr. Graeter called for nominations from the floor. There being none, the panel was unanimously elected.

The president expressed appreciation to the officers and members for cooperation and interest in the activities of the Society during his administration, and extended his good wishes to the new president, Dr. David B. Levine.

Dr. Edward Wolfson, Program Chairman, introduced Dr. Samuel R. Deich. Dr. Deich then introduced the members of the panel: the Honorable Maurice A. Kaltz, Judge of Compensation; Carl Gelman, Esq. and Arthur F. Mead, Esq., members of the Bar Association; Dr. Joseph F. RuBacky and Dr. Jack Sall, members of the Medical Society.

The subject of the panel was "Disability Evaluation in Compensation Cases" and was exceptionally interesting and informative. A question and answer period followed.

A collation was served following adjournment.

IRVING CHRISMAN, M.D.

Reporter

Salem

On May 20, at Richman's Dining Room in Sharpstown, the annual dinner meeting of the *Salem County Medical Society* was held. Seventy persons, including Society members, their wives and guests attended. A delicious dinner of roast beef and baked ham was served.

The meeting was opened by County Society President, Dr. Ford Spangler, who introduced the honored guests. These included Dr. and Mrs. Wegryn of Elizabeth, official representatives of Dr. Ralph M. L. Buchanan, the new State Society President. Dr. and Mrs. E. Gardner Jacobs of Media, Pennsylvania, were introduced to the guests. Dr. Jacobs is one of the attending psychiatrists at the Salem County Guidance Center.

The president then discussed briefly the sociologic implications of the several measures now pending in Congress with reference to Government aid for farmers and health for the aged. Congratulations were extended to the Salem County Medical Society Woman's Auxiliary for the recent awards they won at the State Convention in At-

lantic City. After thanking his officers for their support during his term as President, Dr. Spangler then installed the Officers for the coming year. They are as follows: President—William L. Sprout, M.D.; Vice-President—Wilbert R. Staub, M.D.; Secretary—George F. Reichwein, M.D.; Treasurer—Donald A. McLean, M.D. and Reporter—John T. Dooley, M.D.

After the installation of officers, the meeting was turned over to the new President, Dr. Sprout. The latter, after accepting the gavel of office, outlined his plans for the coming year. Then a film entitled "Seconds for Survival" was shown. This had been made available through The New Jersey Bell Telephone Company. The film dealt with the construction and use of communication in the National Defense Program and in other spheres of civilian life.

JOHN T. DOOLEY, M.D.

Reporter

Book Reviews • • •

Arthritis and Allied Conditions. A Textbook of Rheumatology. Edited by Joseph Lee Hollander, M.D. Philadelphia 1960. Lea and Febiger. Pp. 1306, 417 illus. Ed. 6. ($20.00)

Since its first edition in 1940, this text has been the undisputed source of knowledge and reference in its field. Each of 39 contributors was chosen for his knowledge and ability to pass on such information in a readable, thorough and concise manner.

There is minimal excursion into complicated hormone and connective tissue chemistry; only that, which is essential to a basic understanding.

Nothing of the original edition's promise has been lost. Each edition has advanced the clearer exposition of its knowledge to the reader. Through the talents of the contributors the subject of rheumatic disease is made to sound deceptively simple. Of course this is not so, as is evidenced by the scope of the book.

The sixth edition is enhanced by the inclusion of new subjects: Selye and Baljusz on stress; Castor on connective tissue; Shulman and Harvey on systemic lupus erythematosus and other exciting chapters.

A particularly attractive feature, the "boxed" resume, has been retained in this sixth edition. This is an excellent device for clarifying and tabulating the substance of the preceding pages. Over 400 clear illustrations supplement the text.

I can find no honest adverse criticism of this book, except that it is too cumbersome for bedtime reading.

A rheumatologist will have this new sixth edition on his book shelf; the internist, orthopedist and general practitioner should have one; the new physician, fresh from medical school can hope for one . . . if each is to treat rheumatic disease in an intelligent and up-to-date manner.

EVELYN Z. MERRICK, M.D.

Medicine Today: Report on a Decade of Progress. By Marguerite Clark. New York 1960. Funk and Wagnalls. Pp. 360. ($4.95)

The medical editor of *Newsweek* here reviews in down-to-earth fashion the major medical advances of the 1950s. The scope of the book is indicated by chapter titles such as "State of the Mind"; "The Riddle of Cancer;" "Body and Mind;" "Arthritis and Rheumatism." Mrs. Clark never writes down to her reader. On the whole, she presents solidly supported material which is not overdramatized in spite of the glamorous nature of the subject. The book will prove a source reservoir for physicians called on to lecture to lay groups.

ULYSSES M. FRANK, M.D.

Structural Psychology. D. K. Stanley-Jones. New York 1960. Pergamon Press. Pp. 179. ($6.50)

In a laudable effort to unite mind and brain and find a physiologic basis for the emotions, Dr. Stanley-Jones presents this ingenious thesis. The alternating rhythm of night and day led to a cycle in which, during the daytime, the mind-body was associated with aggressiveness, hunger, rage and defense against cold. During the night, the cycle was featured by warmth, satisfaction of hunger, and "lust." Lust is originally symbolized by sucking; rage by biting. Thus, thermostatic control is hooked into the basic life cycle, and this in turn becomes attached to sexual activity. The baby has a double reaction to the mother—the sucking-lust reaction when the nipple is offered; the frustrated-rage reaction when it is removed. Here is the origin of the Oedipus complex, with the hatred-part of the cycle displaced to one parent.

Anxiety neurosis, the author says, is due to coitus interruptus. The "biting" component of coitus is seen as essential to preserve its balance. "Couples who discover that a good bite is the proper consummation of intercourse are freed of anxiety . . . inhibition of coital biting leads to anxiety; its indulgence, to the absence of anxiety." And, Dr. Stanley-Jones adds, "the primary purpose of orgasm is the discharge of coital rage which, if not so released, appears as anxiety."

Superimposed on this rather mechanical explanation of anxiety is a curious mystical superstructure. "The nucleus of every spermatozoon holds the pattern of the father's cortex, therefore, of the father's mind. There is physical continuity of mind between generations, to all eternity past and future. Reason is stronger than faith and does not need faith. It relies on the evidence of the senses."

The book is readable, provocative and uncompromising. At times the reader may have to tighten his seat belt as he flies into the upper atmosphere. But he won't be bored.

HERBERT BOEHM, M.D.

Your Child's Care. By Harry R. Litchfield, M.D. and Leon H. Dembo, M.D. New York, 1960. Doubleday. Ed. 2. Pp. 257. ($3.95)

The format in this book is unusual in that the questions (and there are 1001 of them) form the headings for 1000 topics. Questions relating to the same topic are grouped under general headings, such as Feeding, Clothing, Allergies, Behavior Problems, Accidents and Emergencies. Included are many newer concepts.

This handy work is compounded out of many years of experience by the authors. Its purpose is to give mothers basic information without lengthy discourse. This second edition has added the newer knowledge of Rh factor, cystic fibrosis, rabies, cerebral palsy and epilepsy.

Many of the answers in the early part are vague and have an "either, or" quality, allowing mothers a preference in procedures. Some recommended procedures are frowned upon by other authors. *Examples*: the authors recommend the strapping of protruding navels, and circumcision when foreskin cannot be retracted. These procedures have been condemned as unnecessary by many authors. Furthermore, one wonders if the market isn't being glutted with "Baby Care" books, none of which see eye to eye with the others on methods.

With these books, the pediatrician's load will be lightened because of fewer telephone calls. But the tyranny of the printed word can cause parental anxiety and rob mothers of spontaneity. However —and in spite of this *obiter*—this book is useful and informative for the young mother.

RALPH N. SHAPIRO, M.D.

Strike Back at Arthritis. U. S. Public Health Service in Collaboration with the Arthritis and Rheumatism Foundation, Washington, 1960. U. S. Government Printing Office. Pp. 45. Paper. ($0.40)

For the millions affected by arthritis, the most distressing problem is limitation of their ability to engage in useful activity. Arthritis, too often produces a seriously disabled person.

In the absence of specific measures to prevent or cure most of the arthritic diseases, modern management is directed at controlling the effects of these diseases. There has been an increasing awareness in recent years of the dangers of immobilization in producing disability. This suggests that crippling occurs when there is needless limitation of the movement of affected joints. Much of this crippling can be prevented. Effective preventive measures include exercises which preserve or improve the range of motion of the involved joints.

This book presents exercises and other procedures which can be effective in preventing the crippling results of immobilization. It will be an aid to physicians in prescribing for their arthritis patients, and in instructing them in proper care.

This brochure at 40 cents is one of the best bargains any doctor interested in rheumatic diseases can get.

HERMAN H. TILLIS, M.D.

Meaning and Methods of Diagnosis in Psychiatry. By Thomas A. Loftus, M.D. Philadelphia, 1960. Lea and Febiger. Pp. 170. ($5.00)

Dr. Loftus has written a clear and concise book which, in 170 pages, conveys more usable and valuable information than many volumes three or four times its size. Non-psychiatrists, as well as young psychiatric residents, will be able to understand his clear language.

The first chapter deals with the meaning and method of diagnosis, discussing different classifications now in use. Short references are made to the historical background of our present nomenclature.

The chapters on psychiatric history-taking and the psychiatric examination, which fortunately stress the importance of a thorough physical examination, are excellent.

In a chapter on comparative histories, Dr. Loftus presents the histories, symptoms and findings of the major reaction types in column form; thus enabling the reader to compare the differential diagnostic features at a glance.

The final chapter recites a number of case histories and asks the reader to select the important diagnostic symptoms and to make his own diagnosis; thus giving an opportunity to test his diagnostic abilities. Each chapter is followed by a good bibliography.

This small volume can be highly recommended to the general practitioner and to the beginning psychiatrist.

FELIX A. UCKO, M.D.

Pardon My Sneeze: The Story of Allergy. Milton Millman, M.D. San Diego 1960. Kuchirka Books (Frye & Smith, Ltd.) Ed. 2. Pp. 213. Soft binding. ($4.00)

Printed in giant-sized type, this is a layman's manual of allergy. It includes many cartoons and a half a dozen scientific illustrations. Dr. Millman is particularly interested in the food allergies, though some attention is given to other factors. One feature of the book is a collection of recipes and menus. The practitioner should determine for himself whether the text is scientifically sound. If he believes it is, he might want to recommend the book to some of his patients. The lack of an index seriously reduces the usefulness of the text. The volume will be helpful to physicians called on to give lectures on allergy to lay groups.

ULYSSES FRANK, M.D.

Source Book of Medical History. Edited by Logan Clendening, M.D. New York 1960. Dover Publications. Pp. 685. Soft Binding (originally published in hard covers 1942). ($2.75)

Not every one will enjoy reading English translations of classic works, perhaps a thousand years old. The language often appears turgid as well as quaint. But to the genuine scholar there is something thrilling about reading in their own words the manuscripts that made medical history—to read, for instance, Crede's original description of ophthalmia neonatorum; or Harvey's first description of the circulation; or Pare's account of the management of gunshot wounds. Here are Sydenham's words describing chorea, and Roentgen's first account of x-rays. Dr. Clendening introduces each section with useful comment and a brief supplementary bibliography. This is a unique volume, making us friends with the cosmic figures of medical history.

HENRY A. DAVIDSON, M.D.

Care of the Well Baby. K. S. Shepard, M.D. Philadelphia, 1960. Lippincott. Pp. 224 with 31 illustrations. Paper. ($3.25)

This is an excellent, practical handbook for students, nurses, interns and residents. Here, much of the information needed to help a mother with a problem is readily available. Those responsible can also have some immediate answer to the uncomplicated problems of newborn.

Most of the disease classifications are oversimplified, a fact which makes the book unusable for the pediatrician or general practitioner who sees many children. But this increases its value for the neophyte. As a matter of fact, medical people need some practical handbook concerning the everyday problems not taught in medical school, such as: "normal" abnormalities; allergy and child health; circumcision; orthopedic "normals" and variants; rectal skin tags; temperature and tongue tie.

Thus this highly selective age group of children (from birth to 2 years) is given special practical treatment, helpful to many students in hospital or clinic settings.

E. P. DUFFY, JR., M.D.

The Office Assistant. Portia Frederick and Carol Towner. Philadelphia 1960. Saunders. Pp. 407. ($5.25)

In his race against the clock, the private practitioner can be enormously helped by an aide—usually female—in his office. She may have to be a receptionist, laboratory technician, purchasing agent, practical nurse, typist, editor, bill-collector, telephone operator, bookkeeper, chaperone, and housekeeper. Where to find such a jewel? One way is to take a bright girl and let her read these chapters—one a day for 26 days. Here she will learn how to sterilize a surgical dressing, use *Index Medicus*, handle a bounced check, take a case history, prepare footnotes, work with a collection agency, prepare solutions of various kinds, dispose of persistent detail men, prepare a letter for the doctor declining to serve on a civic committee, give a hypodermic and fill out insurance forms. All this for $5.25!

VICTOR HUBERMAN, M.D.

Congenital Malformations. Edited by G. E. W. Wolstenholme and Cecilia M. O'Connor. Boston 1960. Little, Brown and Company. Pp. 308. ($9.00)

This book contains the papers and discussions of a Ciba Foundation Symposium in London. This seminar provided a forum for people in differing lines of research to contribute to better understanding of the causes of, and to an even hoped-for ultimate prevention of, the human tragedy of congenital malformations. The program here reported, is focused on an effort to fertilize, organize and bring to successful maturity a world wide effort to eliminate avoidable congenital abnormalities.

It appears after perusal of this remarkable volume, that there is a long way to go before any degree of finality can be reached in the subject of congenital abnormalities; however, aided by the opportunities offered by Ciba Foundation Symposia for comparison of methods and conclusions, dedicated scientists, in all branches, may be encouraged enroute.

MARY BACON, M.D.

NOTE TO READERS

The annual reports and transactions of the House of Delegates are bound together in this issue of THE JOURNAL.

Actions taken by the House of Delegates are indicated in bold face type in the reports.

The other activities of the annual meeting will be published periodically in THE JOURNAL.

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Official Transactions of the House of Delegates

195th ANNUAL MEETING OF

THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J.

MAY 13 - 17, 1961

ANNUAL REPORTS

President

(Reference Committee "A")

JESSE MCCALL, M.D., Newton

The annual report of the President of The Medical Society of New Jersey offers an opportunity for a factual accounting of his stewardship as well as philosophic comments on existing problems and the past, present, and future of the Society. In the past, both avenues of expression have been indulged in. It is a matter of personal choice that I confine myself largely in this report to an accounting of stewardship.

Since my accession to the high office in May of 1960, I have travelled some fifteen thousand miles on missions in the interest of the Society. This has involved between ninety and one hundred separate assignments pertaining to a wide variety of Medical Society problems.

Meetings of the American Medical Association were attended in Miami Beach in June 1960 and Washington (D.C.) in November-December 1960. Other out-of-state conferences under A.M.A. auspices required visits to Baltimore, Maryland (conference on aging); Hershey, Pennsylvania (national legislation); and Washington, D. C. (State Chamber of Commerce).

I attended, on invitation—and with pleasure and profit, the annual meeting of the Pennsylvania State Medical Society, which was held in Atlantic City in October 1960. An invitation to attend the annual meeting of the Delaware State Medical Society had to be declined because of other commitments.

Within the state, I have regularly attended the monthly meetings of the Boards of Trustees of The Medical Society of New Jersey, the Medical-Surgical Plan of New Jersey, and the Hospital Service Plan of New Jersey. Meetings of a liaison nature and to develop specific projects have been carried out with the State Bar Association, State Dental Society, State Nurses' Association, State Optometric Association, New Jersey State CIO, New Jersey Chiropodist Society, Tuberculosis and Health Association, New Jersey Heart Association, Licensed Nursing Homes Association, Health Insurance Council, New Jersey Cancer Society, and others. In appropriate instances in the above-mentioned meetings, I have been able to depend upon the able assistance of the Executive Officer and the Executive Committee of the Board of Trustees.

Stimulation for better liaison with component county societies was provided by a Conference of Presidents in June 1960 at Deal. Although there are many intangibles to be considered in assaying the worth of such a conference, I believe it has proved that worth during the past year and should be continued as standard operating procedure.

During the year I have had the great privilege of visting, on invitation, a large number of the county societies. Only a few such invitations have been nullified by the faulty planning of the weather bureau and the accepted restrictions of a twenty-four hour day.

In the name of the Society I have participated in three radio broadcasts, delivered under the auspices of the Rutgers University Forum. Two of these—delivered last summer and designed to reach a half million New Jersey citizens—dealt with the "Simon Report" and the

cost of medical care. A third broadcast of a debate with a representative of the New Jersey State CIO was aired only recently, and concerned itself with proposed legislation to amend statutory law governing medical service corporations in New Jersey. The official position of the Society in regard to this proposed legislation reached your desks through the medium of the *Membership News Letter.*

It would be well to point up the status of important issues affecting medical practice which have developed or have shown major progress during the year, and I focus attention on the following:

1) The Falcone Case . . . Awaiting appellate decision.

2) The Legislative Commission to Investigate the Administration of Hospital Service Plan of New Jersey (Dumont Commission) . . . I have appeared informally before the Dumont Commission and formally testified at the first (September 26, 1960) and the fifth (December 8, 1960) public hearings, as the official representative of The Medical Society of New Jersey. The formal presentation in each instance has reached you through the medium of the *Membership News Letter.*

On direct examination by the Commission, further emphasis was placed on the following: (a) The basic integrity of The Medical Society of New Jersey, exemplified through almost two centuries of service to the citizens of New Jersey; (b) our never-ending dedication to the humane principle that those who need medical care shall have it, regardless of circumstances; and (c) refusal to be panicked by "scare" stories into a position where we endorse a plan of medical care which dilutes the quality of performance by debasing the medical dollar and substitutes paternalism for independence.

At the fifth public hearing of the Dumont Commission, the position of opposition of the Medical Society in regard to proposed legislation designed to control medical fees under the Blue Shield contract was clearly and emphatically defined. At this writing, the final report of the Dumont Commission is not available, but there is reason to believe that our presentation has been received with sympathy and discernment, and that the final recommendations of the Commission will reflect this discernment and not seriously impair the high economic and social standards which we now apply in the distribution of medical care.

3) Riders (Blue Cross-Blue Shield) for extended benefits covering diagnostic services outside a hospital . . . In accordance with the mandate of the House of Delegates in special session in March 1960 and in regular session in May 1960, the possibility of developing a plan of Blue Shield payment, for services in radiology and pathology rendered in the outpatient departments of hospitals by hospital-employed specialists in these departments, was explored to the ultimate with negative results. Following this impasse, Hospital Service Plan submitted to the Department of Banking and Insurance a petition for a separate rider covering these services. At this writing, the special committee appointed by the direction of the House of Delegates to protest a separate Blue Cross Rider has just completed its interview with the Commissioner of Banking and Insurance, and will be prepared to submit a report to the House of Delegates.

There have been other important developments affecting the Society which deserve mention. Blue Shield now employs a special advisory committee, the membership of which was suggested by The Medical Society of New Jersey, to consider and recommend action in the cases of disputed bills arising under subscriber and participating physician contracts.

For a number of months, the Medical Society has recognized deficiencies in the public relations coverage of Blue Shield—deficiencies which have reflected unfairly on subscriber, participating physician, and the public in general. Your Board of Trustees has been insistent that this be corrected, and feels satisfied that steps in the proper direction have been taken by the recent employment of a separate public relations consultant by Medical-Surgical Plan.

In line with the suggestion made on several occasions during the past, we have tried during the year to solve various problems by direct conference with representatives of Blue Cross, Blue Shield, commercial insurance carriers, hospital associations, representatives of state government, labor, and many other groups who have an interest in total medical care. I should like to be able to report specific *solutions* arrived at in any one or all of these conferences. It woud be fairer, however, to report *progress.* Our contacts with labor during the year have been somewhat disappointing, although predictable. On three occasions meetings with labor representatives have resulted only in a clear definition of the desire of this very important group of our citizenry to so amend present statutory law governing medical service corporations as to remove the necessary safeguards governing the appointments of boards of trustees of such corporations, and the present regulations in regard to percentage of available participating

physicians. We have consistently maintained a position of no compromise in this area, and the members of the Legislature as well as the members of the CIO should have no doubt in their minds as to our belief that such amendatory legislation is not in the best public interest.

In spite of the maintenance of liaison committees with various professional groups throughout our state, we are occasionally embarrassed—or at least discomfited—by public expressions, press, radio, etc. which suggest that problems which we share with dentists, nurses, hospitals, and others need a sharper definition in our mutual pursuit of the goal of first-rate public medical care. Our difficulty has been that many liaison committees have functioned only on call, and then as "trouble-shooting" rather than "planning" units. To correct this fault, your Board of Trustees recently authorized the development of an annual meeting of the liaison committees—probably early in the calendar year—supported by regular meetings of the executive secretaries of the professional groups concerned with health services (medicine, nursing, pharmaceutical, dental, and hospital) throughout the year, at intervals of six to eight weeks.

Evidence of the splendid work of your other officers, councils, and committees will be found in appropriate annual reports. I have made an effort not to duplicate items referred to in these reports, except in a general way. All of these reports will reveal a degree of dedication, industry, and sacrifice, of which the profession and the people of New Jersey may be justly proud.

The full and seemingly tireless devotion of the Executive Officer, the Administrative Secretary, and the entire staff in the Trenton office has been mine from the beginning. I am sure that many of their days have been modified by drudgery and routine; and yet they have by skillful performance removed these days from my ken, and developed a complete cooperative effort in which I have been able to play a prideful part.

Approved (page 382)

Secretary

(Reference Committee "A")

Marcus H. Greifinger, M.D., Newark

The Secretary's office continues its usual routines which primarily involve correspondence, telephone inquiries, and completion of questionnaires, all of which originate from sources too numerous to detail.

During the past year the Secretary attended the annual meeting of the American Medical Association in Miami, and the interim meeting in Washington; and, at state level, the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

AMA MEMBERSHIP

5,775 members of The Medical Society of New Jersey maintain active membership in the AMA. Consequently, the Society's representation in the AMA House of Delegates continues to total six delegates, one for each thousand members, or fraction thereof.

MEMBERSHIP

(as of December 31, 1960)

Active:	Paid	6,006	
	Exempt	269	6,275
Associate			392
New and reinstated members:			
	Active	161	
	Associate	189	350
Members deceased			71
Transfers in-state			24
Transfers out-of-state and resignations			39
State Emeritus			134
State Honorary			4
Members dropped:			
	Active (nonpayment of dues)	24	
	Associates not advanced to active status	16	40
AMA members			5,775

MEMBERSHIP DIRECTORY

The 5th edition of the Membership Directory, 1961-1962 issue, will include listings of all members in good standing in this Society as of June 1, 1961, with publication and distribution of the volume being scheduled for the coming summer months.

The change in format which characterized the 4th edition has allowed the office to submit copy for known text changes, additions, and deletions to the printer at regular intervals since the last publication. Commencing in January, members have been constantly reminded, through THE JOURNAL and *The Membership News Letter,* to submit to the Membership Directory Department any changes in their listings.

It is requested that component societies submit all membership reports to the Executive Offices promptly and prior to the June 1 deadline, so that complete membership listings may be published.

Approved (page 382)

Nominations for Honorary Membership

MARCUS H. GREIFINGER, M.D., Secretary, Newark

In accordance with the provisions of Article IV, Section 7, of the Constitution—Honorary Members—the following nominations for election to Honorary Membership are offered for consideration and action by the House of Delegates:

Elmer L. Shaffer, Ph.D., Trenton
Selman A. Waksman, Ph.D., New Brunswick

The nominations have followed the procedure outlined in the Constitution:

1. Dr. Shaffer was nominated by the Essex County Medical Society, and Dr. Waksman by the Board of Trustees of The Medical Society of New Jersey.

2. Both nominations were submitted to the Committee on Honorary Membership, approved by that committee, and approved by the Board of Trustees before December 1, 1960.

3. The nominations were officially transmitted to the component societies on November 29, 1960.

4. A majority of the component societies have approved the nominations which validates them for submission to the House of Delegates: of the 18 counties reporting, the nomination of Dr. Shaffer was approved by 14, disapproved by 2, and 2 took no action; the nomination of Dr. Waksman was approved by 18. No reports were received from 3 component societies.

First Session Vote: "Nominees may be elected by a two-thirds (2/3) vote of the House of Delegates at the first session."

Third Session Presentation: "Presentation of the honorary membership shall be made at the closing session of the House of Delegates."

Tabled [split vote 142 to 52] (page 389)

Treasurer

(Reference Committee "B")

DANIEL F. FEATHERSTON, M.D., Asbury Park

A complete annual report cannot be submitted at this time as the fiscal year does not close until May 31, 1961. An interim report, prepared and certified by the auditor, covering the accounts from June 1, 1960, through March 31, 1961, is presented below:

BALANCE SHEET — MARCH 31, 1961

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$ 81,299.49	
Executive Office Revolving Account	10,000.00	$ 91,299.49
Savings Accounts:		
Bloomfield Savings Bank, Bloomfield	$ 10,000.00	
Howard Savings Institution, Newark	10,000.00	
Morris County Savings Bank, Morristown	7,516.43	
Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	5,480.44	
First National Bank and Trust Co., Camden	10,000.00	
First National Bank, Westville	10,000.00	
Asbury-Manasquan Bank and Trust Co., Asbury Park	10,000.00	72,996.87
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$ 10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$214,296.36
Accounts Receivable		5,229.55
Inventory—Maternal Welfare Record Books—(at cost) (contra)		5,689.70
Investments—U. S. Savings Bonds and Treasury Notes		146,004.38
Land, Buildings, and Equipment (contra)		148,367.69
Total Assets		$519,587.68

LIABILITIES, RESERVES AND SURPLUS

Employees' Payroll Deductions	$ 1,711.81
Assessments Collected, Applicable to 1961-62	110,858.56
Unexpended Budget Accounts, 1960-61 Fiscal Year	51,439.47
Annual Meeting Reserve	25,621.65
AMA Dues Payable	11,343.75
American Medical Education Foundation	27,266.74
House Reserve	832.69
Membership Directory Reserve	2,275.49
Extraordinary Legal Reserve	497.25
Maternal Welfare Record Books Reserve (contra)	5,689.70
Land, Buildings, and Equipment Reserve (contra)	148,367.69
Surplus	133,682.88
Total Liabilities, Reserves, and Surplus	$519,587.68

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1960-61

JUNE 1, 1960 — MARCH 31, 1961

RECEIPTS — GENERAL FUND

Cash Balance, June 1, 1960					$293,161.41
Assessments:	AMA Dues	AMEF	State Dues	Total	
Atlantic County	$ 3,875.00	$ 780.00	$ 5,420.00	$ 10,075.00	
Bergen County	12,125.00	3,031.86	21,317.18	36,474.04	
Burlington County	2,400.00	496.69	3,476.62	6,373.31	
Camden County	7,175.00	1,506.72	10,546.56	19,228.28	
Cape May County	700.00	140.00	980.00	1,820.00	
Cumberland County	2,050.00	459.18	3,214.11	5,723.29	
Essex County	29,025.00	6,519.38	45,627.16	81,171.54	
Gloucester County	1,400.00	295.00	2,050.00	3,745.00	
Hudson County	12,475.00	2,755.91	19,290.75	34,521.66	
Hunterdon County	1,200.00	240.00	1,680.00	3,120.00	
Mercer County	5,737.50	1,201.73	8,461.54	15,400.77	
Middlesex County	7,350.00	1,501.72	10,511.56	19,363.28	
Monmouth County	6,150.00	1,464.20	10,249.04	17,863.24	
Morris County	5,700.00	1,166.71	8,166.58	15,033.29	
Ocean County	1,700.00	354.18	2,479.11	4,533.29	
Passaic County	10,525.00	2,650.07	18,549.83	31,724.90	
Salem County	1,175.00	236.67	1,656.66	3,068.33	
Somerset County	1,575.00	328.34	2,298.32	4,201.66	
Sussex County	925.00	190.00	1,330.00	2,445.00	
Union County	13,475.00	2,768.48	19,378.04	35,621.52	
Warren County	950.00	205.01	1,434.98	2,589.99	
Total Assessments	$127,687.50	$ 28,291.85	$198,118.04	$354,097.39	
AMA Dues Refunds				$ 12.50	
Journal Advertising (net)				53,104.56	
Annual Meeting Exhibits				17,487.47	
Interest				3,280.46	
Sale of Maternal Welfare Record Books				713.30	
Payroll Deductions				1,711.81	
Refunds of Budget Expenses, 1960-61				288.76	
Janitorial Services				100.00	
AMA Dues Collection				31.25	
Membership Directory				292.80	
Prior Years' Assessments				120.00	
Meeting Services				100.00	
Total Receipts					$431,340.30
Total					$724,501.71

DISBURSEMENTS — GENERAL FUND

Budget Accounts:		
A-1	Executive Salaries	$ 38,307.25
A-2	Exeeutive Office Salaries	32,261.13
A-3	Exeeutive Office Expenses	1,371.89
A-4	Exeeutive Travel	1,685.20
A-5	House Maintenance	13,342.77
A-6	Treasurer	2,223.69
A-8	Secretary	821.94
A-9	Salary Taxes	1,590.42
A-10	Insurance	4,677.52
C-2	Council on Legislation	2,709.54
C-3	Council on Public Health	1,250.16
C-4	Council on Public Relations	5,933.92
C-5	Council on Medical Services	559.51
D-1	President and Presidential Officers	4,885.25
D-2	AMA Delegates	3,800.13
D-3	Woman's Auxiliary	6,694.59
D-5	Conference Groups	55.53
D-6	Directory, Credentials, Membership Records, and Physicians Placement	1,232.92
D-7	Committee on Disaster Medical Services	.52
D-11	Committee on Medical Defense and Insurance	299.15

E-1 Board of Trustees	2,408.81	
E-2 Contingent	3,232.36	
E-3 Judicial Council	565.18	
E-4 Legal	4,270.84	
E-6 Contribution to Medical Student Loan Fund	5,000.00	139,180.22
Purchase of U. S. Treasury Bills		119,504.38
Accounts Payable, May 31, 1960		21,887.58
Journal Publication		51,755.89
Journal Office Expenses		456.94
Journal Commissions		3,730.31
Annual Meeting Expenses		4,226.38
Transfer to Medical Student Loan Fund—Interest on MSLF Bonds		319.56
AMA Dues Collection		965.37
Assessments Refunded		467.48
AMA Dues Remitted		117,562.50
American Medical Education Foundation		30,429.34
House Reserve Payments		3,087.85
Purchase of Maternity Welfare Record Books		6,250.00
Extraordinary Legal Reserve Expenses		9,502.75
Budget Expenses for 1959-60 Fiscal Year		878.80
Total Disbursements		$510,205.35
Cash Balance, March 31, 1961		214,296.36
Total		$724,501.71

MEDICAL STUDENT LOAN FUND

ASSETS

Cash	$ 10,340.50
Notes Receivable—33 loans to 25 medical students	28,975.35
Investments—at cost	25,939.84
Accrued Interest	672.32
Fund Balance, March 31, 1961	$ 65,928.01

DESIGNATIONS

General Fund	$ 59,091.01
Albert Barker Kump Memorial Grant	5,407.00
Joseph E. Mott Memorial Grant	1,430.00
Fund Balance, March 31, 1961	$ 65,928.01

CASH RECEIPTS AND DISBURSEMENTS

Cash Balance, June 1, 1960		$ 10,074.45
Receipts:		
Budget Appropriation from General Fund	$ 5,000.00	
Contributions	4,763.00	
Transfer from Annual Meeting Reserve	2,138.81	
Interest on Investments	664.24	12,566.05
Total		$ 22,640.50
Disbursements:		
14 Loans to Medical Students (10 new, 4 repeats)		12,300.00
Cash Balance, March 31, 1961		$ 10,340.50

SHORT-TERM INVESTMENTS

As recommended by the House of Delegates a few years ago, short-term investments have been made from the general fund as market conditions and the balance in the operating account have permitted. This procedure will be continued.

Approved (page 383)

Board of Trustees

LUKE A. MULLIGAN, M.D., Chairman, Leonia

(Reference Committee "A")

As in past years the report of the Board of Trustees will highlight only the major business considered and acted upon during the year and will cover such items as are not reflected elsewhere in the reports. The majority of the Board's activities of the year have been published in THE JOURNAL. The Society's business has made extremely heavy demands upon the time of the trustees. Twelve regular and one special meetings will have been held between the annual meetings. In addition, the numerous Board committees have been called upon to meet frequently.

The Board's activities, as will be noted from the following items, have been, in the majority of instances, concerned with specialized subjects, which are referred to other reference committees for consideration in connection with the main subjects to be considered by those reference committees.

The Board of Trustees regularly has dealt with general matters brought to its attention —correspondence and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this society; nomination of candidates to the State Board of Medical Examiners; consideration of an action on the reports and recommendations of the several standing committees and administrative councils and their special committees; cooperation with the departments of the State government, and with the allied professions—dentistry, pharmacy, nursing, legal, and hospital administration.

To insure that the position of the Board will be emphasized concerning significant matters contained in its report to the House of Delegates, the Board is presenting specific resolutions to the House dealing with such significant matters and setting forth the position of the Board. Such resolutions are referred to other reference committees for consideration in connection with the main topics of consideration.

In order to set forth the attitude and opinions of the Board on matters to be considered by the reference committees, the President, at the direction of the Board, has assigned one or more members of the Board of Trustees to each reference committee.

Approved (page 382)

COMMUNICATION BETWEEN THE BOARD AND COMPONENT SOCIETIES

(Reference Committee "A")

Following the 1960 meeting, at its re-organization session, the Board of Trustees expressed its deep concern over the attitude evidenced in the House of Delegates which indicated there was some feeling that the component societies are not informed of policies adopted by the Board. The President was authorized to send a letter to each component society stating that the state officers are willing to visit each society on invitation and requesting that the letter be read in an open meeting of the component society.

It was the thought of the Board that when such visits are made, the officers might point out the avenues of communication which exist between the counties and the Board of Trustees, which avenues apparently are not being used to the fullest advantage at present.

Seventeen invitations were received from the component societies and 14 visits were made by the President and/or Executive Officer during the year.

Accepted, with suggestion that, on invitation, Trustees from each Judicial District might attend county society meetings more often in an attempt to keep them more informed on state level procedures (page 382)

MEDICARE PROGRAM

(Reference Committee "C")

The required work in connection with the Medicare Program this past year has continued at diminished volume in comparison to the work required during the first two years of the Program. The special committee has considered twenty disputed claims and several supplemental agreements to the contract.

Eleven of the claims were settled satisfactorily, the other three are still pending.

Approved (page 384)

MSA BOARD OF GOVERNORS—NOMINATIONS

(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey for 1961-62 were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Approved (page 384)

MSP BOARD OF TRUSTEES—NOMINATIONS

(Reference Committee "C")

Nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey for 1961-62, were approved by the Board of Trustees of The Medical Society of New Jersey with the recommendation that the constitution of MSP be amended to increase the number of Plan Board Members by two; and that Jesse McCall, M.D. and Richard I. Nevin be elected as Plan Board Members. It was also recommended to the Plan Board that a representative of labor be considered for membership on the Plan Board. In an official communication from MSP, it was announced that the Plan bylaws have been amended to create two additional vacancies; that a nominating committee has been appointed, and that the names of Dr. McCall and Mr. Nevin will be considered, and that further consideration will be given to the election of a representative of labor to membership on the Plan Board.

The following nominations are referred to the House of Delegates for action:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Robert G. Boyd
Charles L. Cunniff, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Jerome G. Kaufman, M.D.
Joseph M. Keating, M.D.
Samuel J. Lloyd, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Duane E. Minard, Jr.
Glennis S. Rickert, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
James H. Spencer, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Gustave E. Wiedenmayer
Ralph M. L. Buchanan, M.D.

The following additional nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey for 1961-62 were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

F. Clyde Bowers, M.D.
Andrew P. Dedick, Jr., M.D.

Approved, with the request that the listing of doctor-members of MSP Board of Trustees include their type of practice and the component society of which they are members (page 384)

RETIREMENT PLAN FOR PHYSICIANS

(Reference Committee "D")

The special committee met and discussed two retirement plans which were submitted. Neither plan was found to be acceptable nor did either offer anything better than an individual physician could acquire for himself.

Since the AMA has appointed a committee to study the entire question of retirement plans, it was agreed that no action be taken at this time and that the committee await the report of the AMA committee and the action of the AMA thereon.

Approved (page 385)

HEALTH OFFICER QUALIFICATIONS

(Reference Committee "E")

The 1960 House of Delegates adopted a resolution from the Passaic County Medical

Society "that the Legislature be requested to pass an appropriate amendment to the statute entitling physicians duly licensed in this State to serve as Health Officers without further license." Following the annual meeting the resolution was referred by the Board of Trustees to the Council on Legislation. The council submitted a report of the Legislative Analyst, and an opinion from the Commissioner of Health, concerning the resolution; both held that such legislation would be a retrogressive step in public health in New Jersey. The council recommended, and the Board approved, that the report of the Legislative Analyst, in which the Commissioner of Health concurred, together with that of the Commissioner, be referred back to the House of Delegates. They read as follows:

1. Report of Legislative Analyst

Along with other medical specialties, Public Health is a field of medicine requiring special knowledge, training and experience. This has been recognized by the American Medical Association with its recognition of the American Board of Preventive Medicine and Public Health and with its approval of residencies for field training in public health.

To practice the specialty of Public Health, a physician needs knowledge of Biostatistics, Environmental Sanitation, Epidemiology, Sociology, and Public Administration, as well as Communicable Disease Control, Maternal and Child Health, and Chronic Disease Control.

Residency training programs in Public Health have been established with the approval of the American Medical Association. These programs are designed to provide the physician with the necessary supervised practical training and experience to qualify him to hold responsible positions in the field of public health. The requirements of the New Jersey State Public Health Council are not nearly as rigid or exacting as those of the residency programs recognized and approved by the American Medical Association.

As of April 1, 1961, local health departments in New Jersey will be required to comply with the "Recognized Public Health Activities and Minimum Standards of Performance for Local Health Departments in New Jersey" as prescribed by the Public Health Council. To comply with these standards the licensed local health officer must direct a program, including among others, the following activities:

1. Collection and analysis of Public Health Statistics
2. Air Pollution Control
3. Bathing Place and Camp Sanitation
4. Food, Housing and Milk Sanitation
5. Public Water Supply Control
6. Sewage Disposal Control
7. Solid Waste Disposal Control
8. Stream Pollution Control
9. Veterinary Public Health
10. Control of Communicable Diseases
11. Chronic Disease Control
12. Health Education

Without special training and experience, it is not possible for the average physician to direct these activities.

To allow physicians to engage in the practice of this specialized field without the necessary special training and experience would create a dangerous precedent in other specialty fields of medical practice. The training and experience requirements to qualify physicians to practice specialties (surgery, internal medicine, pediatrics, as well as public health) have resulted from long experience in improving the practice of these fields. To strike one down could very well endanger all of the others.

2. Opinion of Commissioner of Health, Roscoe P. Kandle, M.D.

I appreciate the opportunity to comment on the Resolution from the House of Delegates regarding health officer qualifications. The action of the Council on Legislation is sincerely appreciated. The action suggested in the Resolution would, in my opinion, be a retrogressive step in public health in New Jersey for the following reasons, in addition to those presented by the Legislative Analyst, with which I concur.

The responsibilities of a local health officer in New Jersey are concerned to a major degree with environmental sanitation and with state and local laws. Technical knowledge of such fields as sewage disposal, food protection, many aspects of housing are not usually gained during medical training. Knowledge of laws and enforcement practices require local study. Many details such as percolation tests or chlorine residual determinations, while relatively simple, are crucial to good performance as a local health officer.

Establishment of qualifications for and examination of health officers, including medically-trained applicants, has served New Jersey well for 45 years. It has been a sustained, good force in raising the standard of local health officers. This relatively minor inconvenience has not discriminated against medically-trained candidates. This equitable method has, on the contrary, demonstrated the seriousness with which the examination procedure was applied. You will be interested in learning in this regard that examinations for public health officers in New Jersey are prepared by the American Public Health Association which is under contract with many states to prepare examinations for licensing physicians, as well as health officers, and others practicing healing arts. Appraisals applied to the examination as a whole and to individual items by experts in examination technics have, to a very creditable degree, demonstrated that

the test selects well among knowledgeable candidates. Experience has demonstrated, too, that the requirement of procuring a license tends to discourage casual acceptance of the responsibilities of a health officer.

New Jersey urgently needs more full time, well prepared health officers and any move which might encourage any other system is not desirable in the long run.

The Department and the Examination Board would be glad to work with The Medical Society of New Jersey in efforts to devise better methods of recruitment, selection and training of competent local health officers who can serve the people better in this important aspect of health services.

Approved

Action of 1960 House of Delegates, adopting original Resolution #10, rescinded (page 386)

POLICY DECISION — INTRODUCTION OF LEGISLATION

(Reference Committee "E")

The following actions of the Board of Trustees, adopted on recommendation of the Council on Legislation, are directed to the attention of the House of Delegates:

1. Action of Board on January 4, 1953: In consequence of an extended analysis of the technical difficulties involved in the preparation and presentation of sound legislation, and upon the advice of legislative counsel, all committees and agencies of The Medical Society of New Jersey wishing to present legislation for enactment hereafter formally notify the (subcommittee) Council on Legislation of that intent, and supply it with the necessary information and material at least six months—and preferably nine months—in advance of the official beginning of the next legislative year.

2. Action of Board on August 21, 1960: That the Board of Trustees reaffirm its action of January 4, 1953, and that the entire membership be reminded of this policy; and in conjunction therewith, an operational procedure be initiated whereby resolutions for presentation to the House of Delegates recommending the introduction of legislation on the part of The Medical Society of New Jersey be submitted to the Executive Offices at least one month in advance of the annual meeting at which they are to be acted upon, with the understanding that, if approved, legislation will not be introduced until the following legislative year.

3. Action of Board on October 16, 1960: That the policy decision concerning the introduction of legislation, reaffirmed by the Board at its August 21st meeting, be transmitted to the secretaries of all component societies and hereafter to the chairmen of all reference committees for their guidance, pointing out that request for legislation must be carefully processed, if the effectiveness of the Council on Legislation is to be preserved in dealing with legislative matters of medical interest.

Recommendation number two was published in the September, 1960 issue of the *Membership News Letter*; recommendation number three was transmitted to the component societies on November 10, 1960 and has been transmitted to the chairmen of the 1961 reference committees.

It was the conclusion of the Council on Legislation that resolutions calling for the introduction of legislation are sometimes prepared and sponsored on the basis of inadequate information. The result is that the House of Delegates, instead of presenting a request through proper channels with sufficient time for thorough investigation and verification of all the facts involved, occasionally makes mandatory the introduction of legislation for reasons which cannot be adequately supported. An example of this is the resolution regarding Health Officer Qualifications which was adopted by the 1960 House of Delegates and which, with supporting evidence, is referred back to the House this year.

Approved (page 386)

MEDICAL-LEGAL TESTIMONY

(Reference Committee "F")

Since the Spring of 1948, the question of impartial medical witnesses has been under study by special committees of the Society and by the Board of Trustees. Numerous conferences have been held with representatives of the State Department of Labor concerning workmen's compensation cases, with representatives of the New Jersey State Bar Association, with representatives of the New Jersey Supreme Court, with representatives of the National Association of Compensation Claims Attorneys, and with representatives of insurance carriers.

During these past thirteen years, at least a half-dozen proposals have been drafted and accepted by the joint committees for the establishment of a mechanism to provide impartial medical testimony in trial courts. Each such proposal was turned down by the State Bar Association.

In 1959 at the request of the special committee, authorization was granted for the committee to confer with the Chief Justice of the

Supreme Court of New Jersey and/or the Administrator of the Courts, for the purpose of urging that the Supreme Court consider changing its rules so as to permit the members of a panel of impartial medical witnesses, set up by The Medical Society of New Jersey, to be available at the call of the Court, to examine and give testimony in cases in which there is marked divergence of medical professional opinion. Following an informal, exploratory conference of the committee with the Chief Justice, he appointed a special committee from the membership of the Court Rules Committee to study the whole problem with the Society's special committee. In addition, the joint group was asked by the Chief Justice to consider the possibility of having a panel of doctors and lawyers to evaluate malpractice cases to determine their merit.

Beginning in the fall of 1959, the joint committee held a series of meetings. Two rules were drafted, one which dealt with impartial medical witnesses, and the other which dealt with professional liability suits. These rules, as finally approved by the joint committee—the Society's committee acting with the authorization of the Board of Trustees to approve the rules if they were found to be completely satisfactory—were presented by the Special Committee of the Court Rules Committee to the Fall Judicial Conference, held November 18, 1960, in Atlantic City. The plan was to be offered as a pilot study in four counties—Essex, Morris, Union, and Warren. Upon invitation from the Court Committee, four representatives of the Society attended the Judicial Conference—Dr. Allman, Dr. Wegryn, Mr. Nevin, and Mr. Backes.

At the Judicial Conference, the proposed rule dealing with medical expert testimony was opposed by a number of trial lawyers and by the President of the New Jersey State Bar Association, Judge Labrecque. Justice Steuer of the New York Supreme Court was a forceful speaker in favor of the plan, and Judge Waugh, of the New Jersey Superior Court, spoke in support of it. It is the opinion of some members of the Society's special committee that the Justices of the New Jersey Supreme Court favor the rule and are anxious to have the pilot study. However, nothing further has been heard about the rules since the Judicial Conference.

It is the sentiment of the Board of Trustees that from a public relations standpoint, if this latest proposal fails, the courts—and the public of New Jersey, if need be—should be informed that through the consistent efforts of The Medical Society of New Jersey the medical profession of New Jersey has tried to do something constructive to improve the present situations in these areas of court concerns. If no modifications of present rules are adopted it is to be hoped, in all fairness, that continuing dissatisfaction with the prevailing situations will not result in unmerited criticism of the medical profession of New Jersey, which from the record is demonstrably willing but unable to effect improvement, without the cooperation and support of the Bar and the Bench.

Approved (page 387)

PROPOSED RELATIVE VALUE INDEX FOR NEW JERSEY

(Reference Committee "F")

Action of 1960 House of Delegates: That the proposed Relative Value Index be referred to the component societies for study and determination of the wishes of their members; the results of the foregoing to be reported to the Board of Trustees by November 1, 1960; and that the Board present the results to the next meeting of the House of Delegates, annual or special.

The above action was transmitted to the component societies on June 17, 1960, and the remaining copies of the proposed Index were distributed to the counties at that time. Few replies were received from the counties by November 1, 1960, and the counties were canvassed twice again, in October and in February. The following is a resume of the county reports:

Proposal approved:

- Cape May County
- Cumberland County
- Passaic County
- Salem County
- Somerset County
- Sussex County

Proposal disapproved:

- Camden County (see resolution #7)
- Middlesex County
- Monmouth County
- Ocean County
- Union County

Proposal still under study:

- Bergen County
- Essex County
- Hunterdon County
- Morris County
- Warren County

Proposal modified to satisfy local circumstances; proposal as amended approved:

Burlington County

Proposal tabled "pending further request":

Mercer County

No report received from:

Atlantic County
Gloucester County
Hudson County

A communication from the New Jersey Society of Internal Medicine recorded that Society as "in favor of the proposed Relative Value Index."

Accepted (page 388)

PILOT PLAN FOR EYE CARE ON FUNDED BASIS

(Reference Committee "G")

The Pilot Plan for Eye Care on Funded Payment Basis—proposed by the Special Committee on the Conservation of Vision and approved by the Board of Trustees last year—was referred back by the 1960 House of Delegates for further study; and the House directed that the "Plan" be published and circulated to the membership for detailed examination before any implementation is undertaken.

The proposal was published in the August, 1960 issue of THE JOURNAL, pages 499-500; and on November 10, 1960, a communication was sent from the Executive Offices to the component societies soliciting their opinions of the "Plan."

The following replies were received:

Proposal disapproved:

Bergen County
Camden County (*)
Essex County (*)
Gloucester County
Hunterdon County
Mercer County
Middlesex County
Monmouth County
Salem County
Union County
Warren County

(*) Substitute proposals submitted, both of which were referred to, considered, and disapproved by the Special Committee on the Conservation of Vision

Proposal still under study:

Cumberland County
Sussex County

No report received from:

Atlantic County
Burlington County
Cape May County
Hudson County
Morris County
Ocean County
Passaic County
Somerset County

Accepted as information in view of the approval of the recommendation of the Special Committee on Conservation of Vision that the Plan be disapproved (page 389)

SUPPLEMENTAL REPORT

NEW JERSEY SUPREME COURT DECISION IN THE CASE OF FALCONE VS. MIDDLESEX COUNTY MEDICAL SOCIETY

(Reference Committee "A")

At the meeting of the Board of Trustees on the evening of May 12, 1961, the decision of the Supreme Court sustaining the findings of the Superior Court in the case of Falcone vs. Middlesex County Medical Society was protractedly discussed. The Board accepts the conclusion of legal counsel that in direct consequence of that opinion the Middlesex County Medical Society must accept Dr. Falcone as an active member.

It is the opinion of legal counsel that in the light of this Supreme Court decision that any graduate of an osteopathic school recognized by the State Board of Medical Examiners, who also has an M.D. degree from a school recognized by the A.M.A., and who is fully licensed to practice medicine and surgery in New Jersey has a legal right to be considered for membership.

However, the Board is engaged in further study of the implications of the opinion and has already directed correspondence in this connection to the American Medical Association. When the full significance and effect of the opinion have been agreed upon, the Board

will report to the component societies and to the membership.

Approved (page 382)

PERSONAL BUSINESS PROPERTY TAX LAW

(Reference Committee "B")

The Board of Trustees, at its April meeting, directed that legal counsel investigate the significance of the new personal business property tax law, to make proper inquiry to determine if the Society is entitled to an exemption to the law on the basis that it is a nonprofit organization, and to request in the name of the Society a postponement of the filing date for the personal property return from June 15 to September 15.

Last evening (May 12), legal counsel reported that in the early part of May, Governor Meyner signed Senate Bill #175, which postpones for one year application of the new law.

In view of the postponement of the application of the law, counsel felt that there is no need to apply for a postponement of the filing date for the Society, and as for the filing for exemption, this should await further clarification of the law during the coming year.

The same considerations apply to the responsibilities of individual members of the Society in relation to this law.

Received as information (page 383)

MSP PUBLIC RELATIONS COUNSEL

(Reference Committee "C")

The Board of Trustees this year continued to urge the Plan Board to engage its own public relations counsel, not a physician, with salary to be paid completely by Blue Shield, who would be responsible exclusively to the President and Board of Trustees of Blue Shield.

Notice was received that the Plan Board, at its February meeting, had authorized the engagement of a qualified individual whose salary will be paid entirely by MSP, who will be responsible to the Executive Vice President, and whose efforts in the field of education and information will be coordinated with the existing Public Relations Department of MSP and HSP. Use of the word "coordinated" was understood to mean "processed through." The new employee will be paid by MSP outside the 40 to 60 per cent division of public relations costs.

The Board was in agreement that the Plan's action was a compromise, but it is a step which can be taken immediately without interfering with the Joint Operating Agreement. Potential achievements of this appointment will be the disassociation of identities of Blue Cross and Blue Shield and the elimination or reduction of the public's confusion about the two Plans, the development of sympathetic understanding of the sound character and purpose of the Plan, of its economy and low cost, and of the physicians' part in creating and maintaining it.

The Board of Trustees took the following actions on the appointment:

1. That the Board record its approval of this arrangement as potentially adequate but that it reserve the right, after a proper interval, to review the entire operation and at that time to make such further recommendations as it deems desirable.
2. That the Board be memorialized to reconsider this particular problem annually at the time that the nominations for the Plan Board of Trustees are considered, and at the expiration of the "proper interval" proceed to weigh the adequacy of this new arrangement.

A further communication from MSP reported that Mr. Franklin H. Romaine had been engaged for the position, and that Mr. Romaine would join MSP on a full-time basis on May 1, 1961.

Approved (page 384)

BLUE CROSS RIDER FOR DIAGNOSTIC SERVICES

(Reference Committee "C")

At the March, 1960, special session of the House of Delegates, the following action was taken: The President was authorized to appoint a committee to wait upon the Commissioner of Banking and Insurance for the purpose of opposing the issuance of a separate Blue Cross rider for diagnostic services; and the committee was empowered to study the question with Blue Shield and Blue Cross.

The House of Delegates, at the 1960 annual meeting, directed "that study be continued by the Hospital Association and the Medical Society to evolve a method for payment by Blue Shield for diagnostic x-ray and diagnostic pathology done in the out-patient department of the hospital at the direction of the attending physician," and that "any ac-

tion taken must be with the approval of a regular or special meeting of the House of Delegates."

In consequence the matter was considered by the Medical-Hospital Liaison Committee. After every phase and aspect of the recommendation, its implications, and ramifications, had been discussed, representatives from the Hospital Association unanimously declared that no such method for payment by Blue Shield is acceptable because radiologists and pathologists are under contract with hospitals to render hospital services.

In view of the attitude of the Hospital Association, it was felt that no alternative remained except for the special committee to appear before the Commissioner of Banking and Insurance to oppose a separate Blue Cross rider for diagnostic services. The special committee drew up a brief of arguments opposing the issuance of such a rider. The President of Hospital Service Plan was informed that the Society had been unable to reach agreement with the Hospital Association and that if Hospital Service Plan were to present its rider to the Commissioner, the special committee would appear before the Commissioner to oppose it.

Early in July, 1960, a special joint meeting of the Boards of Trustees of The Medical Society of New Jersey and Medical-Surgical Plan of New Jersey was held for discussion of a rider submitted on June 28, 1960, by Hospital Service Plan of New Jersey for consideration of the State Department of Banking and Insurance. It was the majority opinion of the two Boards that the proposal as submitted was in effect for a joint rider, and would be so viewed by the House of Delegates. It was also the majority opinion that submission of the rider to the Commissioner of Banking and Insurance was in violation of the Plans' operating agreement.

On August 8, 1960, Hospital Service Plan submitted to the Commissioner "for review and comment" a proposed separate Blue Cross rider for diagnostic services which, if marketed, would sell for approximately one-half of Blue Shield Rider A and would be available only to subscribers not holding Blue Shield Rider A. The Commissioner was immediately requested to take no action on the Blue Cross rider until a hearing was granted to official representatives of the Medical Society to discuss with the Commissioner "all the implications and consequences of such Hospital Service Plan Rider" and "the reasons why The Medical Society of New Jersey opposes issuance of such a rider."

In a January meeting with the Commissioner on another matter, the Commissioner stated that he had delayed setting a date to meet with the Society's special committee to discuss the Blue Cross rider because he felt the matter was proper to medicine and the hospitals; and that he hoped it might be settled without his being placed in the middle. A meeting with the Commissioner, held on March 29, 1961, was attended by the members of the special committee, the President, the Society's counsel, and the Commissioner and his counsel. The Commissioner reiterated his opinion that the disagreement is between medicine and hospitals, and that he could not act as the arbitrator in the disagreement. He further declared that from the insurance standpoint the separate Blue Cross rider was in order, and that he would approve it. He did feel, however, that Hospital Service Plan does not want to sell this rider, but would proceed to do so if no joint rider could be agreed upon.

At its April meeting, the Board of Trustees was informed that the Commissioner had sent a letter to Hospital Service Plan accepting the filing of the Blue Cross Rider and from the date of receipt of that letter, Blue Cross had been in a position to issue such a rider. However, the Board was also informally notified that neither Hospital Service Plan nor the Hospital Association would take any specific action to issue the rider until the matter of a joint rider was discussed by the Medical Society at its forthcoming annual meeting.

In view of all the foregoing developments, it is the unanimous **recommendation** of the Board of Trustees, in which the special committee joins, that the House of Delegates reconsider the entire matter with the objective of approving a joint rider. To that end it submits to the House of Delegates Resolution #9, MSP-HSP, Joint Rider for Diagnostic Services (see page 365).

Approved (page 384)

Judicial Council

(Reference Committee "A")

ISAAC N. PATTERSON, M.D., Chairman, Westville

The Judicial Council met five times during the year, and presents the following resume of its operations and those of county judicial committees for the year now ending April 10, 1961:

By the Judicial Council:

Appeal Hearings Granted ... 4

Three have been disposed of; one is still pending.

Formal Opinions Rendered ... 4

a) Ethical acceptability of listing names of M.D.'s available for emergency calls under a police system which also lists names of D.O's
b) Ethical acceptability of a physician's transporting employees to and from his clinic to render care
c) Ethical acceptability of a physician's selling drugs to his private patients as part of his office practice
d) Ethical acceptability of proposal that physicians profit by disposal of drug samples

Formal Opinions Reaffirmed ... 2

a) Ethical acceptability of the commingling of doctors of medicine with doctors of osteopathy as members of a hospital staff
b) Ethical acceptability of association with osteopathic physicians in a county health fair and in a county interprofessional health council

Clarification ... 1

Distinction between the judicial mechanism and the Medical Claims and Advisory Committees

(N.B. For the information of the membership, these six opinions and the clarification are presented in full as an appendix to this report.)

By County Judicial Committees:

Complaints Reported as Disposed of ... 118

a) Alleged excessive fees ... 72
b) Alleged unsatisfactory professional services ... 29
c) Alleged discourtesies ... 2
d) Alleged unethical practices ... 3
e) Alleged solicitation of patients ... 5
f) Violation of membership requirements 7

JUDICIAL COUNCIL/COMMITTEE RECORDS

The 1960 House of Delegates adopted a resolution calling for exploration of the possibility of securing legislation to achieve confidentiality for all procedures and records of the Judicial Council and the judicial committees of the various component societies. Subsequently the Board referred the resolution for implementation to the Council on Legislation, which—after proper consideration—reported that, in its opinion, to introduce such legislation would be futile "in view of the position taken consistently by the Legislature refusing privileged communications to physicians."

As an effective substitute for the resolution, it was concluded that the intent of the resolution could best be achieved by requiring that complainants in any matters submitted to the judicial mechanism be required to sign a waiver of right to subpoena any records compiled in conjunction with the disposition of their complaint by either the Judicial Council or judicial committees.

In this connection, the Judicial Council adopted the following recommendations:

1) That the Judicial Council make available to all county society judicial committees a "waiver of right" form, which must be signed by complainants as a condition precedent to acceptance of a complaint for consideration and disposition.

2) That the Judicial Council of the American Medical Association consider setting a limited time during which an appeal from state findings may be taken.

The opinion prevailed that with such an interval stipulated, the Judicial Council could then inform county society judicial committees that after a proper interval they need no longer retain for further use original documents and

data which had been accumulated for the processing and hearing of complaints.

3) That the Judicial Council direct the attention of all judicial committees to the desirability and necessity of their returning any original exhibits received in conjunction with any complaint made to the judicial committees, such as originals of prescriptions, letters, bills, etc.

The Council expects to bring the waiver to final form and to distribute it to judicial committees in the near future.

ETHICAL ACCEPTABILITY OF LISTING NAMES OF M.D.'S AVAILABLE FOR EMERGENCY CALLS UNDER A POLICE SYSTEM WHICH ALSO LISTS NAMES OF D.O.'S

(Opinion Adopted February 26, 1961)

The M.D.'s of a certain town established an emergency call system, and listed their telephone number in the county directory and with the local police department and other interested agencies. Shortly thereafter, the osteopathic physicians of the same area established their own system, under the auspices of the local police department. Thus the police department had knowledge of both systems, but it seemed to prefer the system established by the osteopaths.

Subsequently, to eliminate friction and confusion, the M.D.'s voted to drop their own service and to submit their names as available for emergency calls under the police system.

The advice of the Judicial Council was sought concerning the ethical acceptability of this step.

It is the view of the Judicial Council that the mere filing with the local police department of a separate list of doctors of medicine available for emergency calls, to be used by the police department in conjunction with a similar list of doctors of osteopathy, would not violate the proscription of the code of ethics against "voluntary professional association between doctors of medicine and doctors of osteopathy."

The Council has previously defined "voluntary professional association" as: "a relationship of professional cooperation freely entered into and maintained by licensed physicians who function as professional co-equals." Such a relationship is not envisioned here. It is understood there is to be no professional collaboration between M.D.'s and D.O.'s in the treatment of any patient; nor is there to be any conference or consultation. The list of M.D.'s is to be made available for the service of the people of the community. It indicates no professional alliance between the doctors of medicine and doctors of osteopathy, and is not in any sense indicative as acceptance on the part of the doctors of medicine of the doctors of osteopathy as of equal professional status. Therefore the Council finds no infringement of the code of ethics in the arrangement. The doctors of medicine involved must themselves decide if for all practical purposes such a procedure is preferable to maintenance on their part of a separate list and a separate system of emergency medical coverage.

ETHICAL ACCEPTABILITY OF A PHYSICIAN'S TRANSPORTING EMPLOYEES TO AND FROM HIS CLINIC TO RENDER CARE

(Opinion Adopted February 26, 1961)

A member-physician—who contemplated organizing a clinic for "Industrial Medicine" with a few other doctors—asked if it would be considered unethical to provide the necessary transportation of employees to their clinic with their own personnel, as one of the services of the clinic, to reduce the number of work-hours that would be lost in the treatment of industrial cases.

The Council called attention to Chapter I, Section 4 of the former Principles of Medical Ethics of the American Medical Association, which in greater detail discussed traditional positions encompassed in—but not explicitly dealt with—the revision of 1957:

> *Advertising* . . . Sec. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians, or by institutions or organizations is unethical . . . Disregard of local customs and offenses against recognized ideals are unethical.

In view of the above, the Council unanimously concluded that the ethical acceptability of this practice could best be determined at local level. The Council therefore directed that the physician make inquiry directly of his county medical society.

ETHICAL ACCEPTABILITY OF A PHYSICIAN'S SELLING DRUGS TO HIS PRIVATE PATIENTS AS PART OF HIS OFFICE PRACTICE

(Opinion Adopted February 26, 1961)

A member physician solicited a ruling on his request to sell drugs to his private patients in the office as part of his office prac-

tice. According to the physician, his motive was not to increase his income, but rather to pass on to the patients the savings which he could obtain by ordering drugs in bulk from any one of the cut rate drug houses from which physicians receive catalogues almost every month. The savings frequently could amount to 50 per cent or more on ethical drugs.

In considering this inquiry, the Council made reference to Chapter I, Section 8 of the former Principles of Medical Ethics of the American Medical Association; which in greater detail discussed traditional positions encompassed in —but not explicitly dealt with —the revision of 1957:

> *Ownership of Drugstores and Dispensing Drugs and Appliances by Physicians.* Section 8—It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources.

The Judicial Council unanimously agreed that in view of the above, determination of the ethical acceptability of the proposed procedure could only be made at county level. It therefore directed that the physician be guided by the opinion of the Judicial Committee of his county medical society. The county Judicial Committee has jurisdiction and authority in all questions involving ethical and professional conduct.

ETHICAL ACCEPTABILITY OF PROPOSAL THAT PHYSICIANS PROFIT BY DISPOSAL OF DRUG SAMPLES

(Opinion Adopted December 4, 1960)

Inquiry was made of the Judicial Council as to whether or not the disposal by physicians of physicians' drug samples to a local pharmacy providing financial gain to the seller is compatible with the Principles of Medical Ethics and the standards of acceptable professional conduct.

The Council agreed that these samples provided by pharmaceutical houses free of charge to physicians are intended to be used without expense to physicians or patients.

The members of the Council unanimously recorded themselves as of the opinion that the selling of these samples by physicians to any person or agency is both unethical and unprofessional, not only because of the utilization of these free samples for unintended and indefensible personal gain but because the entrusting of them to the custody of any person other than a physician would expose the ultimate user to the dangers of employing pharmaceuticals that are out of date and therefore scientifically undependable.

ETHICAL ACCEPTABILITY OF THE COMMINGLING OF DOCTORS OF MEDICINE WITH DOCTORS OF OSTEOPATHY AS MEMBERS OF A HOSPITAL STAFF

(Opinions Reaffirmed September 25, 1960 and February 26, 1961)

Two separate requests were submitted to the Judicial Council soliciting opinions as to the ethical acceptability of doctors of medicine serving on the staff of a hospital if staff privileges are granted to an osteopathic physician.

The Judicial Council unanimously agreed that the admission of an osteopath to the medical staff of a hospital would contravene Section 3 of the Principles of Medical Ethics of the American Medical Association which proscribes all voluntary professional association of doctors of medicine with doctors of osteopathy. Such admission would in effect put doctors of medicine on the same hospital staff in position of violating the Principles of Medical Ethics of the American Medical Association—to which Principles The Medical Society of New Jersey subscribes (Bylaws, Chapter XII) and on the basis of which the Judicial Council of The Medical Society of New Jersey has made many pronouncements.

In view of this circumstance, the Judicial Council reaffirmed its earlier and frequently repeated opinion, to wit:

> All voluntary professional association between members of The Medical Society of New Jersey and osteopathic physicians is unethical.

ETHICAL ACCEPTABILITY OF ASSOCIATION WITH OSTEOPATHIC PHYSICIANS IN A COUNTY HEALTH FAIR AND IN A COUNTY INTERPROFESSIONAL HEALTH COUNCIL

(Opinion Reaffirmed May 1, 1960)

A county medical society asked if the Principles of Medical Ethics of the American Medical Association and of The Medical Society of New Jersey:

(1) prohibited the granting of permission to a group of osteopathic physicians to set up and man an exhibit in a county health fair, of which the county medical society was one of the official sponsors; and

(2) proscribed the participation of representatives of organized medicine with representatives of osteopathy in a county Interprofessional Health Council.

The members of the Judicial Council weighed the requests carefully and concluded that in each instance there is involved a question of voluntary professional association of doctors of medicine with doctors of osteopathy. They directed that the County be informed that the Judicial Council of The Medical Society of New Jersey, in reaffirmation of previous official opinions—again declares that " all voluntary professional association between members of The Medical Society of New Jersey and osteopathic physicians is unethical."

THE JUDICIAL MECHANISM AND THE MEDICAL REVIEW AND ADVISORY COMMITTEE . . . A DISTINCTION

The judicial mechanism of The Medical Society of New Jersey consists of the Judicial Council and the cooperating judicial committees of the component medical societies. It is the responsibility of the judicial mechanism "to receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society."

Original jurisdiction with reference to all complaints against member-physicians rests with the county judicial committee. Apart from its supervisory function of the entire mechanism, the Judicial Council serves as an appellate tribunal. County judicial committees may receive complaints in writing directly from complainants or may receive complaints referred from the Judicial Council. The committee is then called upon either by informal means to effect an amicable settlement of the complaint between or among the principals involved or, by means of a detailed investigation and hearing, to arrive at a recommendation for the settlement of the complaint.

The recommendation of a county judicial committee for the settlement of a complaint is binding upon a member-physician, although obviously it cannot be made binding upon a member of the laity. Since, however, the submission of a complaint by a lay person to the judicial mechanism for settlement is an act of good faith, it can be assumed—and regularly it so eventuates—that the recommendation of the judicial mechanism for the settlement of a complaint will be accepted by members of the laity also.

Not all types of complaint are acceptable for processing by the judicial mechanism. Only complaints involving questions of ethical and professional conduct are proper to the mechanism. Matters involving alleged infractions of civil law are outside the scope of the judicial mechanism. Indeed—as set forth in the "Regulations" issued by the Judicial Council for the guidance of judicial committees in the processing of complaints—"only when all principals to a complaint agree to submit the matter of the complaint to our judicial mechanism, and give assurance that no court action is pending, contemplated, or completed should the matter be accepted for processing." It is the general recommendation of the Judicial Council that this assurance be obtained in writing before the judicial committee agrees to accept and process a complaint.

When the judicial committee agrees to accept and process a complaint, it is required to report that fact on a supplied report form (A) to the Judicial Council. A period of 60 days is normally allowed by the Judicial Council to a judicial committee for the completion of action with reference to a complaint before it. When the judicial committee, in executive session, has arrived at its recommendation for the settlement of a complaint, it is required to inform the principals of that recommendation and to submit a report of that recommendation to the Judicial Council (Form B).

At the time at which the principals to a complaint are informed by a county judicial committee of its recommendation for the settlement of that complaint, the Judicial Council requires that they also be informed that they have the right of appeal, from the disposition made by the judicial committee, to the Judicial Council. Such appeal must be filed in writing with the Judicial Council by the dissatisfied principal or principals within 45 days of the date of the formal notice to the principals of

the findings of the county judicial committee, and of their right of appeal.

When a request for an appeal hearing is granted by the Judicial Council, formal hearing is arranged as convenient to the calendar of the Judicial Council and decision is rendered, confirming, modifying, or reversing the disposition made by the county judicial committee. Every county judicial committee, under the Bylaws of The Medical Society of New Jersey, "shall have the power to censor, suspend, or expel any member of the Society for just cause."

Appeal from the findings of the Judicial Council may subsequently be taken to the Judicial Council of the American Medical Association.

The Medical Review and Advisory Committee proposed to be established by each component society in conjunction with the Loss Control Program of the new liability insurance coverage will have a distinct and different function. It will deal with claims alleging malpractice on the part of a physician—claims which are properly and exclusively processed through courts of law. It is only in instances where complaints are seeking monetary judgments before civil courts, and in instances where legal defense of the physician-member will be necessary, that this committee has any function.

The purpose of the Loss Control Program is effectively to process such claims and to determine why claims originate, by studying and evaluating claims submitted and complaints filed, and by reviewing the disposition made of such claims and complaints.

The Medical Review and Advisory Committee is intended to assist in effectuating the Loss Control Program. This committee, whose size is as yet undetermined but will probably consist of no more than seven members in all, shall be composed of physician-members except that one member of the committee—it is recommended—should be a non-physician of recognized stature in the community.

Each meeting of the Medical Review and Advisory Committee will be attended by representatives of the insurance carrier and by the company's legal counsel. In consequence of its investigation of a claim or complaint, the Medical Review and Advisory Committee shall make a recommendation to the insurance company concerning the medical defensibility of the matter. When a claim is to be defended, the committee will assist in helping to secure medical testimony.

From the foregoing, I hope it will be clear that the spheres of concern and responsibility of the judicial committee on the one hand and of the Medical Review and Advisory Committee on the other are separate and distinct.

The Judicial Committee has the responsibility to make determinations and decisions in areas involving questions of ethics and professional deportment outside the realm of civil court action.

The Medical Review and Advisory Committee will be expected to advise and recommend concerning disputed insurance claims under the coverage of the Society's official professional liability carrier.

County judicial committees will not touch matters that are intended for ultimate presentation in court. Medical Review and Advisory Committees will be concerned only with such matters as will obviously terminate in court for settlement unless the claimant and the carrier are satisfied by the recommendation of the committee.

Approved (page 382)

Executive Officer

(Reference Committee "A")

Richard I. Nevin, Trenton

Anyone who reads the annual reports of the president and of the other officers and agencies of the Society will know, without assurance from me, that the year now ending has been characterized by a crowding succession of exacting challenges, critical developments, and constructive activities involving our entire organization. Constantly mounting pressures and constantly accelerating speed bestir and bedevil us. There are as many gauges

and indicators of professional and social performance and drift to be watched, interpreted, and reacted to as confront pilots in the cabins of modern air cruisers. We—and all the other agencies and individuals of our time—are impressively, even frighteningly, in motion. Our need is to insure that that motion carries us forward, or at least not backward, or in futile, empty circles.

There is sound basis for the conclusion that in the year now drawing to its close our flight has been controlled and our navigation accurate. In our contacts and negotiations—with the other professions, with the departments and agencies of government, with the legislature, with labor and industry, with social organizations, with the American Medical Association, with our component societies, with our Auxiliary, and with the public—we have consistently emphasized principles and followed policies consonant with the ideal of furthering and advancing simultaneously the true good of the profession of medicine and of the people whom it serves. That true good as yet is neither attained nor assured. But all our efforts are directed toward it, and with every passing day—thanks to the irrepressible vitality of truth—we are being joined by others who, for the general good, make common cause with us.

Our officers and council and committee members have been generous of time and effort as never before. They have met the challenge of more work to be done by simply buckling down and doing it—this not only through intra-society meetings and activities, but more and more by participation in educational efforts—on platforms and off—to make clear to all the wholesomeness of Medicine's dedication to the fundamental welfare of the people and the nation.

For my part—beyond the work at my desk involving the routines of Society business and the exactions of my writing assignments—I have taken part in 191 conferences and meetings (including six trips out of state, and eight visits to county societies) and have filled 16 speaking engagements . . . And I have only been working in tandem with the President, the other officers, and the members of our splendid staff.

The fact is that our greatest problems today do not center upon aspects of physical health or disease. In large part we have learned how to deal with these. Our chief problem—and we share it with all citizens who are solicitous for the strength and survival of our country—is manifest in a politico-social syndrome of transference of responsibility, speciously justified in the name of realistic thinking but actually attributable to the diminution in our citizens of self-reliance, independence, and industrious drive, and the substitution instead of attitudes of self-pity, self-indulgence, and demanding dependence. As a nation we are in jeopardy of losing our physical strength because we are in the process of losing our strength of soul. I offer this observation as no passing philosophical animadversion, but as a dispassionate recognition of a real and tragically significant situation.

There is much to be done to restore the health of contemporary society. Physicians—who render such efficient service in the area of personal physical health—as educated and idealistically dedicated men and women can contribute greatly. In common with all good men and women, they must manifest in their daily living their regard for and allegiance to the attributes of mind and heart which make men strong and free. They must, by action and exhortation, stimulate a rededication to fundamental truth and justice, to independence, industry, aspiration, and attainment. They must help to counter the thinking that a change of our system of government from a free republic to a welfare state would be not regression but progress. They must work with all like-minded fellow citizens to protect the health of our American society by resisting—and urging others to resist—all debilitating changes in it.

This responsibility accounts for a large part of the work in which our Society is now engaged. We are fighting a cold war for the health and survival of our country as a free nation. It is a great and worthy struggle which we *must* bring to successful culmination, or else be resigned to drag out our days as members of a fettered profession, and as the voiceless, choiceless servants of a dictatorial state.

Approved, with recommendation that each member of the Society make special effort to read the report of the Executive Officer (page 382)

Annual Meeting

(Reference Committee "H")

JEROME G. KAUFMAN, M.D., Chairman, Maplewood

With the cooperation of the section officers and the chairmen of the scientific exhibit and program committees, an outstanding program has been arranged for the 1961 Annual Meeting. The section meetings and exhibits will present varied subjects which we believe will have wide appeal among the membership.

Our meeting seems to be increasing in appeal to the technical exhibitors, if applications for space are an indication. All technical exhibit space was reserved early in December, and numerous applications received since that time have been turned down because of lack of space.

The committee cannot emphasize too strongly the necessity for all members to visit the exhibits. The technical exhibitors pay the costs of the annual meeting; in appreciation the members should visit the displays and discuss the companies' products with their representatives. The scientific exhibits will present the results of the latest significant investigations; they are worthy of the attention of every member. The educational exhibits present the latest developments in programs and projects of cooperating agencies.

Through the cooperation of Smith Kline and French Laboratories, an interesting motion picture program has been arranged. Appreciation is again expressed to the company for this valuable addition to our annual meeting program.

In accordance with the recommendation of the 1959 House of Delegates, the exhibits will again open on Sunday—May 14, 1961—to afford the delegates an opportunity to visit the exhibits "since many leave on Monday after the House has adjourned." This early opening will be continued if, in the opinion of the committee, the results are worthwhile.

Because of the increasingly heavy convention schedule each spring in Atlantic City, it has been found advisable to set meeting dates at least four years in advance in order to secure desirable dates and hotel accommodations. The House of Delegates has already approved the following convention dates which have been confirmed with Haddon Hall:

196th meeting — Saturday-Wednesday, May 12-16, 1962

197th meeting — Saturday-Wednesday, May 11-15, 1963

198th meeting — Saturday-Wednesday, May 16-20, 1964

RECOMMENDATION

That the 199th annual meeting be held at Haddon Hall, Atlantic City—Saturday-Wednesday, May 15-19, 1965.

Accepted (page 389)

Scientific Exhibits

(Reference Committee "H")

Milton Ackerman, M.D., Chairman, Atlantic City

The committee met in September, 1960, and January, 1961. The following actions were taken:

1. A review of the exhibit plan, exhibitors, and awards for the scientific exhibit of the 1960 annual meeting. The committee requested that the same space and room allotment be established for the 1961 Scientific Exhibit. The request was granted.

2. The committee discussed and approved a plan for a more efficient lay-out of booths in the assigned exhibit area to permit better flow of traffic and easier visibility.

3. Several minor revisions of the application form were accomplished.

4. All applications received prior to the January, 1961 committee meeting were reviewed, and space was assigned to those accepted. Several applications were refused where their content and subject matter were deemed too commercial for the scientific exhibit. A number of additional applications received since the January meeting have been processed by the committee. All requests for space in the scientific exhibit were granted with the exception of those noted. The committee established a grouping of the exhibits in accordance with subject matter.

5. The committee reviewed a listing of films available for the motion picture theatre. A group of films which, in the opinion of the committee, would be of general interest to the membership of the Society was selected, and a schedule for the showing of these films was established.

6. Exhibitors have been requested to have their exhibits in place by noon on Sunday, May 14. It was decided that the Awards Committee would review the exhibits on Sunday, May 14, and distribution of awards would be accomplished in the morning of Monday, May 15. An Awards Committee to accomplish this has been appointed.

The assistance of the several committee members, of Mrs. Edith Madden and her staff, and, particularly, the advice of the former chairman, Dr. Thomas K. Rathmell, are gratefully acknowledged.

Accepted (page 389)

Scientific Program

(Reference Committee "H")

Edward E. Seidmon, M.D., Chairman, Plainfield

Plans for the 1961 annual meeting scientific program were initiated at a meeting with the section officers in June of 1960. In late September of 1960, a second meeting of the section officers was held at which time the scientific program was outlined. As previously agreed, joint programs were developed, thus reducing to eleven the number of scientific sessions to be presented by the twenty sections.

The annual meeting is a "medical forum," and all sections have heeded our urging that their programs be made attractive to the general membership. We believe this year that some phase of the scientific program will appeal to each and every member. The section officers are to be congratulated for the selection of their topics and their speakers.

The outstanding scientific program which our sections have prepared for presentation at the 1961 annual meeting deserves the recognition and support of the membership. All members are urged to attend the scientific session of their choice.

Accepted (page 389)

Credentials

(Reference Committee "A")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

During its second year of operation, the Committee on Credentials has functioned in a routine manner. Applications for membership were considered and passed upon at monthly intervals.

Since June 1, 1960, the committee considered 227 applications for associate membership, and 207 for active membership. Of the total of 434 applications, 397 were approved. As of April 10, 1961, 40 applications are on hand for consideration and action by the committee.

Last year the committee ruled, and the House of Delegates approved, that former regular or associate members, whose memberships have lapsed for any reason, must submit formal applications for State Committee approval before they may again be accepted as members. Enforcement of this rule has resulted in some confusion, as regards lapsed active membership, because no time limit is stipulated. The committee is in the process of amending the rule, which will clarify the issue and eliminate the confusion.

Approved (page 382)

Finance and Budget

(Reference Committee "B")

DAVID B. ALLMAN, M.D., Chairman, Atlantic City

A review of the expenses and accounts to date indicates that the individual accounts are sound and that a slight balance in the total budget can be anticipated.

JOURNAL

The Committee on Publication is to be congratulated for its continued excellent financial status. Again, no budget appropriation has been requested for the publication of THE JOURNAL, office expenses, and travel. The Committee on Publication will continue to operate on its advertising income.

MEDICAL STUDENT LOAN FUND

The Board of Trustees has authorized the transfer of surplus funds, over $100,000, at the close of the current fiscal year to the Medical Student Loan Fund, on loan and without interest, to enable the Fund committee to carry out its program next year. It is estimated that a transfer of $25-$30,000 will be made in accordance with this action of the Board.

AMERICAN MEDICAL EDUCATION FOUNDATION

For the past two years, the House of Delegates has set the per capita level of contribution to AMEF in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

This method of contribution has resulted in maintaining the budget on an equalized basis. It has also resulted in a larger contribution to AMEF—$30,429.34 in 1960. Your committee definitely feels this method of contribution should be continued.

1961-62 BUDGET

The proposed budget (below) for 1961-62, in the total amount of $218,799.00, has the approval of the Board of Trustees.

1962 ASSESSMENT

The computation of cash surplus at the close of the current fiscal year, less the transfer to Medical Student Loan Fund, is estimated at $120,000—$20,000 above the $100,000 sum which has been indicated as the desired surplus amount at the beginning of each new fiscal year.

The actual 1961-62 budgetary requirement is $39.18 per capita. However, the committee feels that, rather than raise the assessment in 1962, it should remain the same—$35 per capita—and that the difference should be taken from surplus.

RECOMMENDATIONS

1. That the per capita level of contribution to AMEF for 1962 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Adopted at $5.00 per capita (page 383)

2. That the budget for 1961-62 be adopted in the total sum of $218,799.00.

Adopted (page 383)

3. That the 1962 assessment be adopted at $35 per capita with no provision for a contribution to AMEF.

Adopted (page 383)

PROPOSED BUDGET FOR 1961-62

A-1	Executive Salaries	$ 55,108.00
A-2	Executive Office Salaries	52,635.00
A-3	Executive Office Expenses	2,000.00
A-4	Executive Travel	2,405.00
A-5	House Maintenance	15,825.00
A-6	Treasurer	3,130.00
A-7	Finance and Budget	100.00
A-8	Secretary	1,300.00
A-9	Salary Taxes	2,625.00
A-10	Insurance	3,634.00
B	Journal Publication and Office Expenses	(Operates on Advertising Income)
C-2	Legislation	7,500.00
C-3	Public Health	1,700.00
C-4	Public Relations	10,000.00
C-5	Medical Services	1,100.00
D-1	President & Presidential Officers	11,800.00
D-2	AMA Delegates	5,260.00
D-3	Woman's Auxiliary	8,027.00
D-4	Medical Education	100.00
D-5	Conference Groups	1,000.00
D-6	Credentials, Membership, Directory, Physicians Placement	3,750.00
D-7	Disaster Medical Services	100.00
D-9	Archives-History	100.00
D-10	Blood Bank Commission	250.00
D-11	Medical Defense and Insurance	750.00
E-1	Board of Trustees	6,400.00
E-2	Contingent	10,000.00
E-3	Judicial Council	900.00
E-4	Legal	6,300.00
E-6	Medical Student Loan Fund	5,000.00
	TOTAL	$218,799.00

Adopted, with recommendation that there be a breakdown or explanatory footnotes on any items showing a marked difference between current and proposed budgets (page 383)

Honorary Membership

(Reference Committee "H")

MARCUS H. GREIFINGER, M.D., Secretary, Newark

It is with deepest regret that the Secretary submits this report to the House of Delegates occasioned by the death of Dr. Aldrich C. Crowe, chairman, on Easter Sunday, April 2, 1961. Dr. Crowe served his Society ably and well for nearly 35 years—Trustee, President, AMA Delegate, and as chairman of this committee. His passing is noted with sorrow by his colleagues and friends, and sincere sympathy is expressed to his family.

The report of the Committee on Honorary Membership is taken from the committee records on file in the Executive Offices.

In the early spring of 1960, the names of two nominees for election to Honorary Membership were received by the Board of Trustees and referred to the Committee on Honorary Membership for consideration—Selman A. Waksman, Ph.D., of New Brunswick; and Elmer L. Shaffer, Ph.D., of Trenton. Dr. Waksman's name was submitted by the Board of Trustees, and Dr. Shaffer's name by resolution from the Essex County Medical Society.

The Constitution, Article IV, Section 7—Honorary Members—provides:

> Honorary members shall be physicians who have attained distinction with the medical profession; or persons who have rendered signal service to The Medical Society of New Jersey, or who have attained special eminence in scientific fields other than medicine. Nominations shall be submitted by recognized medical groups to the Committee on Honorary Membership, and the committee's action shall be transmitted to the Board of Trustees by December first . . .

In accordance with the above regulation, the committee considered the nominations and, after review of supporting data, approved them. The report of the committee's action was submitted to the Board of Trustees at its meeting on November 20, 1960.

No action, in view of the tabling of the nominations (page 308) at the first session of the House (page 389)

Medical Defense and Insurance

(Reference Committee "D")

DANIEL F. FEATHERSTON, M.D., Chairman, Asbury Park

The committee has met six times during the year. In addition, several conferences have been held with the various insurance carriers. The committee also conducted an appeal hearing on an accident and health policy claim.

ACCIDENT AND HEALTH INSURANCE

This phase of the committee's work progressed satisfactorily with the complete cooperation of the E. & W. Blanksteen Agency.

One arbitration hearing was held on the disability claim of Anthony Ruvolo, M.D., which had been denied by the National Casualty Company. The committee met in formal session with both Dr. Ruvolo and the National Casualty Company being represented by counsel. Witnesses were heard. The committee unanimously decided that the company failed to substantiate its objections to paying the full claim of $600.00 monthly and decided in favor of Dr. Ruvolo. The full committee was present, assisted by Robert M. Backes, counsel for The Medical Society of New Jersey, who had submitted a detailed review of the case file in preparation for the hearing. A full transcript of the notes taken by our Administrative Secretary of the proceedings of the hearing are on file in the Executive Office.

RECOMMENDATION

That the services of the E. & W. Blanksteen Agency be continued as the Society's official broker for the accident and health insurance program.

Adopted (page 385)

LIFE INSURANCE

The committee's work in this program proceeded without difficulty. There were no claims contested, and the company paid out a total of $13,000 in death claims.

RECOMMENDATION

That the services of the E. & W. Blanksteen Agency be continued as the Society's official broker for the life insurance program.

Adopted (page 385)

MAJOR MEDICAL INSURANCE

As directed by the 1960 House of Delegates, the committee reviewed the policies offered by four different insurance companies. The committee unanimously agreed that the policy offered by National Casualty Company, through the E. & W. Blanksteen Agency, was preferable. This decision was reached after a careful and detailed comparison of all plans submitted. The comparative report was made by an independent insurance expert who was not, and is not now, connected with any of the companies involved.

A brief description of the National Casualty proposal follows:

Eligibility:

1. Any member up to age 65 who is in active practice; but once insured, then no age limit.
2. During initial enrollment period only, members between 65 and 70 subject to evidence of insurability.

Dependents:

1. Spouse under 70 at issuance, no age limit thereafter.
2. Unmarried children living with insured and dependent for one-half of support, from 14 days to age 23.

Benefits:

1. $10,000 each accident or sickness until age 70; $5,000 for claims beginning after 70 under conversion policy.
2. Begin when deductible is exceeded within a 12 consecutive month period.
3. Expenses covered for maximum of 3 years, from date of first covered expense.

Co-Insurance:

80 per cent paid by Company.

Enrollment:

Insurance of acceptable eligible members and their acceptable eligible dependents will take effect immediately upon approval of the application by the company. When 50 per cent of the eligible members under age 65, including both acceptable and impaired applicants, have applied during the charter enrollment period, then all applicants who are impaired will become insured, provided they are then under age 65 and engaged in full-time active practice. Impaired dependents will also become insured at that time, provided they are otherwise eligible. (For those age 65 through 69 who apply during enrollment period, policies will be issued only to acceptable applicants).

Other Insurance:

Full payment made; no proration.

Rates:

$500.00 deductible

	To 39	40-49	50-59	60-69	70 & up
1. Insured	10.40	18.20	32.40	52.00	52.00(*)
2. Insured and spouse	22.20	38.00	66.00	103.00	103.00(*)
3. Insured, spouse, children	35.00	50.20	78.20	109.00	109.00(*)
4. Insured and children	23.20	30.40	44.60	58.00	58.00(*)

(*) $5,000 maximum and $750 deductible age 70 and over.

Approval:

Approved by New Jersey State Department of Banking and Insurance.

Deductible:

$500 to age 70; $750 thereafter on conversion policy.

Grace Period:

31 days.

World Wide Coverage:

Yes.

Air Travel in Commercial Liner:

Yes.

Recurrent Disablement:

Treated as new disablement if:

1. Complete recovery from previous disablement.
2. Due to separate and unrelated cause.
3. Expenses don't exceed $50.00 during 3-month period.
4. Maximum of $10,000 paid and return to normal practice for 90 days.

Age 70:

Can continue insurance with $5,000 coverage and $750.00 deductible, whether or not in active practice.

Impaired Member:

If 50 per cent of the eligible members under age 65 apply during the enrollment period, then policies will be issued to impaired members who applied during the enrollment period, if they are under age 65 and in active practice.

Impaired Dependent:

Covered when 50 per cent of members are enrolled, as described above.

Covered Expenses:

DAILY HOSPITAL ROOM AND BOARD
Full charge for ward or semi-private room—private room limit is $30.

MISCELLANEOUS HOSPITAL SERVICES as inpatient or outpatient.

REGISTERED NURSE in and out of hospital.

SERVICES AND SUPPLIES in and out of hospital: Drugs and medicines prepared from a doctor's prescription.
Laboratory and X-ray services, including x-ray and radium treatment.
Anesthesia, oxygen, blood and blood plasma, and surgical dressings.
Rental of iron lung.
Artificial limbs and eyes, casts, splints, trusses, braces and crutches.
Local professional ambulance transportation to and from a hospital for inpatient treatment.

Exclusions:

The plan does not cover physicians' fees nor expenses caused by or resulting from: the hazards of warfare; injury or sickness contracted while in the armed forces; suicide or attempt thereat; self-inflicted injury; injury or sickness covered by Workmen's Compensation or Occupational Disease Law; supplies or services which are furnished by or at the expense of the Federal Government or any agency thereof; treatment for alcoholism or narcotic addiction; air travel, cosmetic surgery, and congenital defects, except as specified in the policy.

The question of a probable conflict with Blue Cross coverage in this area was explored in detail, both by correspondence, conference between the committee and Blue Cross officials, and by President McCall, who is the Society's official representative on the Blue Cross Board of Trustees. In spite of the fact that the policy recommended by the committee for major medical coverage contains a $500.00 deductible feature, Blue Cross is still adamant in opposing it and continues to indicate its displeasure with this situation. However, Blue Cross has not specifically indicated its intention to cancel coverage if and when this policy goes into effect, but a veiled threat of such cancellation has been made. Despite this, the committe reaffirms its recommendation that the Society avail itself of this program for major medical coverage for the membership, feeling that Blue Cross would not be in a very strong position in any attempt to cancel Blue Cross coverage of the membership of The Medical Society of New Jersey, since similar situations exist and have existed for several years with other organizations and groups without any attempt on the part of Blue Cross to cancel their policies.

RECOMMENDATION

That the 1961 House of Delegates adopt the proposal of the National Casualty Company for major medical insurance with $500.00 deductible, and that the E. & W. Blanksteen Agency be approved as the official brokers for this program.

Item referred to Board of Trustees for study and action, and the Board of Trustees also to investigate and consider negotiations with private insurance carriers to furnish these services which we are threatened with being taken away by Blue Cross (page 385)

PROFESSIONAL LIABILITY INSURANCE

The year has produced satisfactory progress in both the sale and administration of the professional liability insurance program, including great strides in the dissemination of knowledge of the loss control program. Personal visits have been made by committee members and the Manager of the New Jersey office of the American Mutual Liability Insurance Company, Joseph A. Britton, to many of the component societies to explain the loss control program. Not all counties have been covered as yet, but it is the intention of the committee to continue efforts toward this end.

The company is pleased with the over-all acceptance of the new policy and offers the following figures as of March 31, 1961:

County	Number of Insurable Members (9-30-60)	Participation Number Insured (3-31-61)	Participation Per Cent Insured (3-31-61)
Atlantic	167	4	2
Bergen	672	179	27
Burlington	99	11	11
Camden	351	8	2
Cape May	36	0	0
Cumberland	95	15	16
Essex	1,566	431	28
Gloucester	69	1	1
Hudson	613	98	16
Hunterdon	53	11	21
Mercer	408	47	12
Middlesex	314	103	33
Monmouth	319	118	37
Morris	259	80	31
Ocean	77	6	8
Passaic	577	148	26
Salem	49	2	4
Somerset	101	29	29
Sussex	40	10	25
Union	603	160	27
Warren	36	15	42
Total	6,504	1,476	23%

It is disappointing to report that in several counties there has been actual opposition on a county-wide basis to both the sale of this policy to the membership and to the loss control program. In other areas complete indifference is exhibited, as is reflected in the list of policy sales. It is hoped that in a short time ths opposition will be overcome and a high percentage of the membership will be covered under this program.

There has been no claim filed against any member of this Society who carries American Mutual coverage, as of the date of this report.

At a January conference of the committee with representatives of the American Mutual Liability Insurance Company, the general manager of the company's California program was present. He explained in detail the experience and workings of the California loss control program. We correlated our program from his experience and the needs of New Jersey. Our program has been distributed to the component societies. The county secretaries and chairmen of insurance committees have also been supplied with an official memorandum from the Judicial Council clarifying the relationships of the judicial mechanism and the loss control program and cautioning them to keep separate the judicial mechanism and the loss control program.

RECOMMENDATIONS

1. That the professional liability insurance program be continued through the American Mutual Liability Insurance Company.

Adopted (page 386)

2. That the component societies give their complete support to the sale of policies and implement the approved loss control program under this approved program.

Adopted (page 386)

The chairman wishes to thank the members of his committee for their faithful attendance at the numerous meetings and for their enthusiastic support of the committee's program. In the name of the committee, the chairman acknowledges the guidance and assistance given by Robert M. Backes, Richard I. Nevin, and Edith L. Madden.

Medical Education

(Reference Committee "D")

SHERMAN GARRISON, JR., M.D., Chairman, Bridgeton

The Committee on Medical Education has forwarded a request to the President of The Medical Society of New Jersey regarding modification of the present Constitutional delineation of function of this committee, which no longer seems pertinent.

The Committee on Medical Education wishes to encourage all hospitals and groups planning educational programs to schedule them in advance whenever possible with "What Goes On" and with the Council on Medical Education and Hospitals of the American Medical Association.

The committee remains available to assist with the organization of programs in medical education at any level.

Approved (page 385)

Medical Student Loan Fund

(Reference Committee "B")

Luke A. Mulligan, M.D., Chairman, Leonia

In its four years of operation, the Medical Student Loan Fund has granted a total of $28,975.35 in 33 loans to 25 New Jersey medical students.

The gross fund totals $65,928.01—$59,091.01, General Fund; $5,407, Albert Barker Kump Memorial Grant; $1,430, Joseph E. Mott Memorial Grant.

With the restriction that disbursements shall not exceed 20 per cent of the total fund on hand in any one year, and with contributions limited as presently they are, the amount which will be available for loans to medical students for their 1961-62 school year will be far below that which the committee already knows will be required. In consequence, the Board of Trustees, at its January meeting, authorized the transfer to the Medical Student Loan Fund on loan without interest, of all monies in excess of $100,000 in the surplus account at the end of the 1960-61 fiscal year; the full amount thus assigned is to be placed at the disposal of this committee for 1961-62.

Approved (page 383)

The goal of the committee is to bring the fund to $100,000, and to that end the committee again urges wide and continuing publicity of the Medical Student Loan Fund to the membership. It appeals for contributions, either to the general fund or as special memorial grants. We reiterate the recommendation of the 1959 House of Delegates: "that all members of the Society think of this fund as a philanthropy to which they judiciously contribute."

1959 action reaffirmed with recommendation that the component societies intensify their efforts to increase the fund due to the increasing demands being made on it (page 383)

The committee is grateful to the many contributors to the fund and takes this occasion to acknowledge their support. A list of contributors to date (4/7/61) since the last report follows:

Albert Barker Kump Memorial Grant—Cumberland County Woman's Auxiliary in memory of Mrs. Clare Mascara; Dr. Frank J. T. Aitken.

Joseph E. Mott Memorial Grant—Passaic County Medical Society.

General Fund—State Auxiliary Executive Board and Fellowettes; Mrs. Ralph K. Bush in lieu of Christmas cards; County Auxiliaries: Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Monmouth, Ocean, Salem, Union; State Auxiliary in memory of its deceased members; Camden Auxiliary in honor of Mrs. George Hager and Mrs. Oswald R. Carlander; Gloucester Auxiliary in honor of Mrs. Ralph K. Bush, Mrs. Floyd D. Gindhart, and Dr. I. Edward Ornaff; Camden Auxiliary in memory of Mrs. Irvin Deibert; Salem Auxiliary in memory of Mrs. Gertrude Jonas. County Societies: Burlington County in memory of Dr. George N. A. Westcoat; and Warren. State Society: In memory of Dr. Joseph E. Mott, A. Lester Soden, Mrs. Helen Bodner, Dr. George N. J. Sommer, Mrs. C. Byron Blaisdell, Thomas M. Madden, Dr. George J. Young, Charles Murphy, Dr. E. Zeh Hawkes, Vincent Gorman, Carl Withers, Dr. Aldrich C. Crowe, and Dr. Lewis C. Fritts. Individual memorial contributions: Mr. and Mrs. Richard I. Nevin, Dr. and Mrs. F. Clyde Bowers, Dr. and Mrs. Samuel J. Lloyd, Dr. and Mrs. Louis S. Wegryn, and Dr. and Mrs. S. S. Ellenson in memory of Mrs. C. Byron Blaisdell; Dr. and Mrs. Samuel J. Lloyd in memory of Dr. George N. J. Sommer, Dr. John Fedor, Dr. Donald C. Lynch, Dr. E. Zeh Hawkes, Dr. James Rita, Carl Withers, and Dr. Thomas Murto; Mr. and Mrs. John T. Madden in memory of James McMillan; Dr. and Mrs. F. Clyde Bowers in memory of Thomas M. Madden; Dr. and Mrs. Millard Cryder in memory of Mrs. Edna M. Endicott; Dr. and Mrs. Samuel M. Diskan and Dr. and Mrs. John F. Perez in memory of Dr. D. Ward Scanlan; Dr. and Mrs. Samuel L. Winn in memory of Dr. D. Ward Scanlan and Mrs. Esther C. Brunstein; Mrs. Margaret B. Stockton in memory of Russell Metzger; Dr. and Mrs. Carl N. Ware in memory of Dr. Aldrich C. Crowe.

Approved, with recommendation that future reports of the committee include a breakdown of the loans granted—by county of residence and by medical school attended (page 383)

Publication

(Reference Committee "B")

FRED B. ROGERS, M.D., Chairman, Trenton

A conspicuous decline in journal advertising throughout the country was a feature of the 1960 budgets of most American pharmaceutical companies. Our JOURNAL, like all other medical periodicals, reflected this decline. Thus, in 1958 we published 1084 pages of advertising material, including inserts. In 1959 this rose to 1162. But in 1960 there was a 4 per cent drop and we published only 1124 pages of advertising. To remain within our budget, we were obliged to reduce text matter, from 748 in 1959 to 718 pages in 1960. We were, however, well ahead of the 1958 figure of 672 pages.

Of our 34 JOURNAL editorials in 1960, at least three were reproduced elsewhere or cited. Indeed, "Profile in the Mirror" (from our February 1960 issue) was quoted by nine different newspapers. This high standard extended to the scientific articles too: at least 17 of the 87 were quoted, reprinted in other periodicals or abstracted. Dr. Karel's paper on civil defense (February 1960 issue) was printed in its entirety in the *Congressional Record*.

On the sad side, we must record the death of Dr. Joseph E. Mott, a valuable member of our small committee. He had served us for 18 years. He died on May 24, 1960 and was succeeded a month later by Dr. Frank L. Rosen of Essex County.

A tabular comparison of the last three years will be of interest.

	Pages		
	1958	1959	1960
Editorials	32	29	30
Original Scientific Articles	291	389	324
Historical Articles	41	13	11
State Activities*	241	242	280
Announcements, Letters Marginalia	19	21	15
County Society Reports	29	31	33
Book Reviews	19	23	25
Pages of Textual Material	672	748	718
Advertising and Inserts	1084	1162	1124
Grand Total (Pages)	1756	1910	1842

* Includes Obituaries, Civil Defense material and Woman's Auxiliary items.

The conspicuous expansion of the "State Activities" section of THE JOURNAL is shown in this table. In the face of decline in other departments, this section expanded from 242 to 280 pages. Our popular book review department—one of the largest in any state medical journal—continues to grow.

THE JOURNAL is, of course, a cooperative venture. We owe thanks to our advertising representatives for bringing in the advertisements that provide the financial fuel for THE JOURNAL. Dr. Davidson continues his leadership on a nationwide level—he is an editorial consultant to several other journals; he is a member of the Student AMA's 3-man essay award group, as well as the author of a standard guide to medical writing. Special thanks are due to Mrs. Miriam N. Armstrong, our Assistant Editor, who keeps the wheels turning in the editorial office with responsibility for advertising, lay-out, bookkeeping, billing, proof reading, and the myriad secretarial and administrative duties of an editorial office. We probably have the smallest office staff (and in terms of its overhead expenses, the most thrifty) of any medical journal of comparable circulation anywhere in the United States.

Your Committee makes no request for funds. Our advertising income during the past six years has always exceeded publication costs. We anticipate that this will be true in 1961 in spite of the decline in pharmaceutical advertising budgets. If advertising continues to fall, we hope to balance this by our usual prudent management with, if necessary, a proportionate reduction in text material in THE JOURNAL.

Approved (page 383)

In recent years we have not accepted advertisements for liquor or contraceptives in THE JOURNAL. Most state medical journals and specialty periodicals do accept such advertisements if they are in good taste and plausibly worded. By refusing such material we, of course, reduce JOURNAL income—a matter to consider in view of last year's decline in advertising funds. In view of our strictly professional circulation and concept of ethical advertising, the Publication Committee requested the Board of Trustees to re-consider this matter at this time. The Board approved acceptance

of liquor and contraceptive advertisements pending acceptance by the House of Delegates.

RECOMMENDATIONS

1. That acceptance of liquor advertisements be approved by the House of Delegates.

2. That acceptance of contraceptive advertisements be approved by the House of Delegates.

Recommendation of reference committee, that such advertisements not be accepted at this time, DEFEATED (page 383)

Revision of Constitution and Bylaws

(Reference Committee on Constitution and Bylaws)

Louis F. Albright, M.D., Chairman, Spring Lake

PROPOSED AMENDMENTS TO ARTICLE VI — BOARD OF TRUSTEES

The standing Committee on Revision of Constitution and Bylaws reviewed proposed amendments to Article VI—Board of Trustees—Sections 1, 2, and 4 of the Constitution submitted by the Union County Medical Society, co-sponsored by the Cumberland, Middlesex, and Ocean County Medical Societies, for consideration of the 1961 House of Delegates.

This committee would like to point out the fact that the proposed amendments are in exactly the same form as submitted last year despite the fact that the standing Committee on Revision of Constitution and Bylaws and the 1960 Reference Committee on Constitution and Bylaws felt that it was patently necessary to alter Section 2 materially to insure the orderly transition from one Board group to the other, selected under the terms of the proposed amendments.

Obviously, the sponsors of these amendments must be aware of the suggestions which previously this committee made in this connection and have chosen not to embrace them. Your committee feels, nevertheless, that failure to effect these changes in the proposed amendments would result in adoption by the House of Delegates of an instrument that not only would embarrass the House and the Board of Trustees but would cripple the conduct of the business of the Society.

Inasmuch as the matter before us is the same as last year, your committee repeats its report of last year.

The primary objective of the proposed amendments is to have representation from each component society on the Board of Trustees. In this instance your committee did not feel justified in taking a position on the proposals—either favorable or in opposition—but proceeded only to study them. But it is pointed out that the following should be carefully considered by the reference committee and the House:

1. Currently the Board of Trustees is composed of 18 members whose reported attendance is almost consistently 100 per cent at all meetings.

2. The Board now meets regularly the third Sunday of each month for an average of 6 to 7 hours each meeting.

3. The proposed amendments would result in a 34-member Board. Consideration must be given to the difficulty of finding men who would attend meetings that frequently and serve that diligently; otherwise it will result in a disservice to the membership, component societies, and the Society as a whole, and thus weaken the functions of the Board of Trustees.

The committee is of the opinion that the proposed amendments should be considered and acted upon by the Reference Committee and the House of Delegates in two steps:

Step 1—Should the composition of the Board of Trustees be changed?

If the answer is "no," then there is no need to consider the proposed amendments.

If the answer is "yes," then the proposed

amendments must be dealt with, and should involve the following determinations:

Step 2—Possible bases of representation on the Board of Trustees (as of current membership)

a. One elected Trustee from each component society (total 21)

b. One elected Trustee from each component society on basis of 500 members or fraction thereof (total 27)

c. One elected Trustee from each component society on basis of 500 members or major fraction thereof (total 23)

d. One elected Trustee from each component society on basis of 1000 members or fraction thereof (total 22)

e. One elected Trustee from each component society on basis of 1000 members or major fraction thereof (total 21)

The committee points out that the simple assignment of one elected Trustee from each component society would make the structure of the Board less complicated than a system embracing proration. The committee also felt that one elected Trustee from each component society would be in keeping with the structure of the State and Federal government since the House of Delegates is based on proration.

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The following changes in the proposed amendments are considered necessary by the committee:

[Words in brackets are deletions from the proposed amendments as submitted by the Union County Medical Society]

Underlined words are changes considered necessary by the committee

Constitution—Article VI—Board of Trustees

SECTION 1—COMPOSITION

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Step 1. Each [County] component society shall be entitled to [at least] one (1) elected Trustee. [and for the] Step 2. The larger [counties they] component societies shall be entitled to one (1) elected Trustee for each five hundred (500) [active or voting] members or fraction thereof as of December 31 of each year. [Each] Trustees shall be elected from and by [his] component [county society] societies prior to the proper annual meeting of the House of Delegates. The term of office shall be three (3) years (subject to the maintenance of membership totals under proration) and such term shall commence upon the expiration of the term of the [former] incumbent. The [term] tenure of office of approximately one-third (1/3) of the elected Trustees shall terminate annually.

Committee note: If proration is not adopted, the phrase in parentheses (subject to the maintenance of membership totals under proration) and the word "approximately" can be deleted.

SECTION 2—PROCEDURE

Committee note: Delete the entire section as proposed inasmuch as there must not be a complete break-up of the Board—incumbent Trustees are entitled to complete the terms for which they were elected, and there must be continuity of direction of the Society through the Board of Trustees.

Substitute the following:

Following the adoption of these amendments incumbent Trustees shall serve out their elected terms as representatives of the component societies in which they hold membership. Remaining and succeeding Trustees shall be elected by component societies the year following the adoption of these amendments for one (1), two (2), or three (3) year terms—to equalize the process.

SECTION 4—FILLING VACANCIES

In the event that the office of any [member] elected Trustee becomes vacant [for any reason] the component [county] society wherein the vacancy [exists] occurs shall elect a [member] successor within ninety (90) days, to fill the unexpired term.

****

Bylaws—Chapter V—Procedure of Election
Section 1—Nominating Committee
Chapter VI—Rights and Duties of Officers
Section 5—Board of Trustees

The proposed amendments to these sections of the Bylaws, also from the Union County Medical Society, were noted. However, inasmuch as their adoption is contingent upon the adoption of the proposed amendments to Article VI of the Constitution and cannot be considered and acted upon until the 1961 annual meeting, the committee will not report on these proposals at this time.

REPRESENTATION IN HOUSE OF DELEGATES

The following resolution from the Bergen County Medical Society was adopted by the 1960 House of Delegates "for referral to and action by the Committee on Revision of Constitution and Bylaws":

Resolved, that the Constitution and Bylaws of The Medical Society of New Jersey be amended to provide:

1. a reduction in the number of delegates from the several county societies to one for every twenty active members of each society, retaining however the same minimum representation as presently is provided for the smaller county societies.

2. incorporation within the framework of the revised portion of the Constitution and Bylaws an escalator clause that will obligate the Board of Trustees to lessen the proportional representation each year in such a manner as to limit the number of delegates to four hundred.

This committee stresses that point 2 assigns a power to the Board of Trustees which presently it does not possess. However, the following amendments are offered for consideration:

CONSTITUTION

ARTICLE IV — ORGANIZATION OF THE SOCIETY

Current	Proposed
Section 4 — Delegates	**Section 4 — Delegates**
(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.	(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each twenty (20) members, unless otherwise stipulated by the House of Delegates in the interest of maintaining the total membership of the House so that it does not exceed four hundred (400) members, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office for each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.
	Amended to read:
	Each component society shall be entitled to one (1) delegate for each twenty (20) members or major fraction thereof, . . .
	APPROVED as amended for final consideration in 1962 (page 391)

ARTICLE V — HOUSE OF DELEGATES

Section 1 — Composition

The House of Delegates shall be the legislative body of this Society, and shall consist of the Fellows, Officers, and Delegates.

Section 1 — Composition

The House of Delegates shall be the legislative body of this Society, and shall consist of the Fellows, Officers, and Delegates, in total not to exceed 400 members.

No Action

Committee report ACCEPTED (page 392)

Advisory to Woman's Auxiliary

(Reference Committee "H")

Lewis C. Fritts, M.D., Chairman, Somerville

The work of the Advisory Committee to the Woman's Auxiliary was minimized throughout the year because of the orderly procedures and cooperative attitudes that characterized the operations and activities of the Woman's Auxiliary. For this circumstance a word of sincere appreciation is due to Mrs. Ralph K. Bush, President of the Auxiliary, and to all the other officers and members who worked with her in achieving a year of harmonious and efficient functioning. That word, in the name of the Committee, I am happy to extend.

Following the precedent of other years, the official programs and projects for the year were submitted and cleared through the Board of Trustees at the beginning of the administrative year. In consequence, it was possible in the early autumn to initiate the integrated activities which carried through the year.

The activities of the Auxiliary are effectively and consistently supportive of the activities of The Medical Society of New Jersey and the component societies. It is difficult to select individual activities for citation, so uniformly meritorious do they seem to be. Nevertheless I would like to point out that this year especial and effective emphasis has been placed by the women of the Auxiliary upon the Medical Student Loan Fund and the drive to bring it to the full quota of one hundred thousand dollars . . . a goal toward which it is advancing.

In another area, too, special efforts have been indulged . . . that is in the preparation for submission to the general assembly of the Auxiliary of a general revision of Constitution and Bylaws.

It has been increasingly gratifying to observe the way in which, with each passing year, coordination of endeavors and cooperation of efforts between The Medical Society of New Jersey and its Woman's Auxiliary have progressed. It indicates a unity of strength which augurs well for the goals and the good of the people and the medical profession in this state.

Accepted (page 389)

Legislation

(Reference Committee "E")

C. Byron Blaisdell, M.D., Chairman, Asbury Park

The Council on Legislation met five times during the year to study current state legislation. As of March 31, 167 bills had been introduced in the Senate and 541 bills had been introduced in the Assembly. From these our Legislative Analyst screened and analyzed all bills of interest to medicine and the public health and welfare. Many of these measures are "repeaters," such as those concerned with examination of suspected drunken drivers; presumed relationship of hypertension and heart disease to service in police and fire departments; the licensing of physical therapists; the structure of medical service corporations; the concession to the Commissioner of Banking and Insurance of the power to control fees and practices of medical service corporations.

The council's legislative bulletins to keymen and county society secretaries have provided each county with the current position of The Medical Society of New Jersey on these and all other bills or resolutions. In addition, the *Membership News Letter* has summarized for each individual member similar information in clear and concise manner, both for last year's results and for this year's problems.

Our position on legislation has been furnished to all the members of the State Legislature, geared to the status of pending bills, when action pro or con seemed indicated.

Two bills have been introduced in behalf of the Medical Society: (1) an amendment to the school examination law, to permit (not require) the school medical inspector to accept a report of a physical examination made upon a pupil by his treating physician, in lieu of the examination which—under present statute—the school medical examiner or the school nurse is directed to make; and (2) an amendment to the Medical Practice Act to extend legal protection to individuals supplying technical ancillary services to licensed physicians who are presently not granted that protection under the law.

Two other bills are being readied for introduction: (1) a "Good Samaritan" law, to protect from liability persons who in good faith render emergency service; and (2) a bill to outlaw entertainment hypnosis.

The legislation affecting public medical care, exemplified by A-10, and which could be tied in with implementation of the Kerr-Mills legislation passed by Congress last year, is under study and amendment by the Commission chaired by Mrs. Marion Yaguda, the staff of the Department of Institutions and Agencies, the New Jersey Public Health Association, the New Jersey Welfare Council, and ourselves and others. Our position is, with the A.M.A., favorable to implementation of the Kerr-Mills legislation, in that it will help the needy and medically needy without involving Social Security payroll taxation. Within the state, however, there is serious concern over county versus municipal jurisdiction and some concern over the division of responsibilities between Welfare and the Department of Health. It is possible that a progress report or some definite action may be furnished the House of Delegates in a supplementary report at Atlantic City in May.

National legislation will be reported in May, by which time the Washington scene may have developed a new look, although it seems probable that social security legislation affecting hospitals and physicians will not be acted upon in the near future.

Approved, and each member of the House of Delegates urged to bring to the attention of his local Board of Education the fact that S-66 (an amendment to the School Examination Law) is permissive, not mandatory, legislation **(page 386)**

SUPPLEMENTAL REPORT

STATE LEGISLATION

Since the preparation of our annual report, two developments in state legislation have occurred concerning which the House may well be informed.

1. A-197 passed in the Assembly on May 8. This bill would eliminate the requirements that (a) nominations to the Board of Trustees

of a medical service corporation be approved by a recognized medical society having not less than two thousand members; and (b) that 51 per cent of licensed physicians must participate in every county.

This bill is supported by the CIO and opposed by The Medical Society of New Jersey. With the help of our legislative keymen, we are making every effort to win the members of the Senate to reject A-197 as contrary to the public interest.

2. A-128—amended in Assembly committee—also passed in the Assembly on May 8. This bill would grant separate licensure to physical therapists. Under the committee amendment, the bill would restrict manipulation of the spinal column to chiropractors; would empower the chiropractor to prescribe and direct the use of physical therapy for patients, as a fully licensed physician now does; and would make the Board of Medical Examiners responsible for licensing and supervising physical therapists but would deny to the Board the right to make and enforce rules in the exercise of that responsibility.

The Medical Society of New Jersey opposes this bill as unnecessary and undesirable in its original form because the present Medical Practice Act is adequate for the recognition and maintenance of status of properly qualified physical therapists. As amended the bill is even less desirable because of its unwarranted discrimination in favor of chiropractors and against the State Board of Medical Examiners.

With the help of our legislative keymen, we are making every effort to induce the members of the Senate to reject A-128-Aca- as unnecessary and unsound legislation.

Approved with recommendation that each member of this House of Delegates express to his state senator the opposition of The Medical Society of New Jersey to A-197 and A-128 (page 386)

NATIONAL LEGISLATION

National legislation was not reported in the council's original annual report, as printed, because of the uncertainties of progress of President Kennedy's program. It would still appear at this time that the King-Anderson Bill (H.R. 4222) will not be enacted soon. This is reflected in New Jersey by Governor Meyner's decision to implement the Kerr-Mills law, after initial reluctance, as has Governor Rockefeller in New York.

It should be our hope that in the integration of the Kerr-Mills law with local state legislation, growing out of the recommendations of the New Jersey Commission on Public Medical Care, that the role of the physician and the State Department of Health will be properly established, and not be subordinate to administrative and fiscal planning.

Briefly, in Washington the situation with respect to legislation in which our interests are most engaged are:

H.R. 10—The House Ways and Means Committee has ordered H.R. 10 (Keogh Bill) favorably reported, despite Administration opposition. The vote on April 26 was 18 to 5. The bill would allow self-employed persons to deduct for income tax purposes 10 per cent of their incomes, up to $2,500 a year, if they invest the sums in specified types of retirement plans. The bill has not yet been formally reported to the House. House passage seems certain. Senate passage appears likely. However, action may be delayed in the Senate until next year because of Administration opposition. Following the vote, Congressman Eugene J. Keogh (D., N.Y.) said: "We have taken a big step in the right direction, and I am confident that after 10 long years of waiting, H.R. 10 will be enacted into law."

Aged Care Bill—Representative Wilbur Mills, chairman of the House Ways and Means Committee, is expected to announce shortly that his committee will hold hearings on H.R. 4222 sometime in June or July. This move may take some of the pressure off the Senate to tack on medical care for the aged provisions to the House-passed social security cash benefits bill. On April 27, Senator Clinton P. Anderson (D., N.M.) re-emphasized an earlier statement that plans were being considered to draft a modified version of the Administration's aged care bill to add to the House bill. Anderson declared: "There has been some speculation in the press that there will be no effort in this session of Congress to get action on President Kennedy's program of health care for the aged. Neither the Administration nor the supporters of this proposal in the Senate, are shelving their interest in the health of our elderly until next year."

In conclusion, inasmuch as I decided long ago that the termination of my trusteeship and the chairmanship of this council should coincide, I wish to express most sincere and deep appreciation for the generous collabora-

tion and support of all those members who have worked on the council and the erst-while Subcommittee on Legislation; and to the staff at our headquarters offices through lo, these many, many years.

The experience has been rich and rewarding, which sentiment I know will, in time, be shared by the council's new chairman.

Approved (page 386)

Medical Services

(Reference Committee "F")

Irving Klompus, M.D., Chairman, Bound Brook

The Council on Medical Services has met twice during the year 1960-61.

The council met jointly with representatives of the Division of Welfare, State Department of Institutions and Agencies, in an attempt to evolve a plan for medical care to the indigent on a vendor payment system. Because the elements of such a plan are still in flux, no final action has been taken. The council stands ready to meet and assist the Division of Welfare at any time.

The Special Committees on Workmen's Compensation and Industrial Health have continued their individual projects during the year and have submitted progress reports to the council from time to time. The details of their activities are covered in their respective reports.

Accepted (page 387)

PROPOSED RELATIVE VALUE INDEX FOR NEW JERSEY

Last year the Council on Medical Services prepared and referred to the 1960 House of Delegates a proposed Relative Value Index for New Jersey, and recommended that it be adopted. The House of Delegates directed that the proposed RVI be referred to the component societies for study and determination of the wishes of their members and that the Board of Trustees present the results of the foregoing to the next meeting of the House of Delegates.

The following statement and recommendation were adopted for inclusion in the council's annual report to the 1961 House of Delegates:

> The Council on Medical Services has reconsidered and restudied the proposed Relative Value Index for New Jersey. Council members have participated in county meetings in an effort to explain the purpose of the Relative Value Index and to answer questions posed by individual members and/or committees. The council has exerted every effort to promote a Relative Value Index for New Jersey as it is still the belief of the council members that such an Index should be adopted.

RECOMMENDATION

That the proposed Relative Value Index be adopted by the House of Delegates.

Reference committee recommendation ADOPTED—further study for another year by all parties concerned, and this matter be presented again at the next meeting of the House of Delegates, annual or special (page 388)

Public Health

(Reference Committee "G")

Robert S. Garber, M.D., Chairman, Belle Mead

Our council meetings this year have attracted a far greater percentage of member attendance than in previous years. This obviously reflects the results of careful selection of interested and dedicated personnel. Nevertheless, there remains a continuing problem for the officers of the council to contend with each year, namely that of a method of expediting the voluminous business items for the members of the council without being hampered by lengthy special committee reports only brought to our attention on the day of our quarterly meeting.

Some of the chairmen of the special committees are extremely conscientious and diligent; others have not responded to the appointment of a liaison member of council to their committee urging them to meet in ample time to submit written minutes for appropriate study. It appears as though a requirement of the Board of Trustees specifically charging the special committees to meet on definite dates at least two weeks before the quarterly council meeting is indicated; rather than entrusting this to the discretion of the committee chairmen.

This year, the council had a number of unusual matters referred to it for discussion:

1. The matter of the sanitary land fills' apparently not meeting the State Public Health requirements in several communities.
2. The contribution of inadequate Mosquito Control programs to the rise of the fatal epidemic of Equine Encephalitis.
3. The shark scare which occurred along the coast this past summer prompted inquiries as to what steps could be taken to initiate constructive solutions.

Appropriate inquiries were directed to the various commissioners on a State level, and as yet these matters remain under study.

We are exceedingly appreciative that the State Commissioner of Health, Dr. Roscoe Kandle, accepted our invitation to serve as a consultant to our committee, so as to provide more effective answers to questions raised at the time of our council meetings.

We note with considerable pride the progress made by our various special committees on such subjects as:

1. Cancer registry in general hospitals
2. Establishment of Hearing Centers throughout the State
3. Re-evaluation of present facilities for the treatment and management of the Alcoholic
4. Constructive steps toward school health examination with emphasis on Tuberculosis testing and controls.

This is not a complete, but rather a representative, list—and attention is directed towards the individual reports of our special committees for more detailed information.

The council has recommended to the Board of Trustees that it specifically charge the chairmen of the special committees to meet on definite dates at least two weeks prior to the quarterly council meetings, so as to provide ample time for the executive offices to reproduce the minutes for appropriate action by the council.

Approved (page 388)

Public Relations

(Reference Committee "E")

John F. Kustrup, M.D., Chairman, Trenton

The Council on Public Relations carried out its functions as outlined by the Constitution and Bylaws and approved by the Board of Trustees. Two full committee meetings were held during the administrative year, together with special conferences of individual members entrusted with responsibility for particular projects.

Among the continuing projects and activities taken care of as perennially basic to the Society's public relations activities were the following:

1. Health Hints . . . The council issued fortnightly *Health Hints* to all daily and weekly newspapers of New Jersey and to numerous house organs which have requested that they be supplied. Twenty-seven separate issues were mailed to a monthly total of 425 selected media of dissemination.

A dependable indication of the widespread popularity and effectiveness of this project is the fact that we have received clippings of 19 separate editorials based upon our *Health Hints* apart from the clippings of full columns from the news sections of the papers.

2. Junior Health Hints . . . The revised edition of Series Two of the Society's *Junior Health Hints* was distributed to the teaching personnel of public and parochial high schools throughout the state requesting it. In all, some 2,794 copies were so distributed, to be used by the teachers as the basis for regular weekly classroom presentations.

3. Membership News Letter . . . By the end of this administrative year, eleven issues of the *Membership News Letter* will have been produced and mailed to the membership, for a total distribution in excess of seventy-five thousand copies.

4. Special News Releases . . . Apart from its regular releases to papers, the council presented special news releases dealing with:

a. 1960 Eye Health Screening Program . . . A release supplied in mid-September to all daily and weekly newspapers and to all radio stations in New Jersey resulted in a clipping return of 149 articles, including 5 editorials and 1 picture.

b. President's Statement in Opposition to A 556 . . . A five-page release was sent under date of 12/8/60 to all dailies of New Jersey.

c. President's Statement to Governor Meyner, Commending and Supporting SCR-27 . . . A two-page release was issued under date of 11/28/60 to all dailies of New Jersey.

d. President's Statement in Answer to Charges Concerning Physicians' Responsibility for the High Cost of Hospital Services . . . A two-page release was sent under date of 4/25/60 to all dailies in New Jersey.

e. 1960 Annual Meeting . . . According to our clipping returns, the annual meeting was written up—in coverage embracing all its features—in a total of 178 newspaper articles, including 20 pictures and 1 editorial.

5. Golden Merit Award . . . This year there are twenty-eight recipients of the Golden Merit Award. Official commemorative plaques will be presented at special ceremonies, to be held on Saturday afternoon, May 13, in the Benjamin West Room, 13th Floor of Haddon Hall. All the details concerning this award are the responsibility of the Council on Public Relations. News items are given to local papers, and individual pictures taken at the time of the bestowal are supplied by the council to all award recipients present in person at the ceremonies.

6. Press Coverage for Annual Meeting . . . The council, for the past several years, has sponsored a press room at the annual meeting. Advance publicity releases are mailed before the convention. This year the press room is located in the Card Room, Lobby Floor of Haddon Hall. It is supervised by the Administrative Assistant to the Executive Officer, and the direction of its activities is his responsibility. Members of the council assist in the activities of the press room and are available to help arrange for necessary interviews. Through the press room information is given to press representatives, interviews are arranged, and publicity pictures scheduled. Advance and spot news releases are handled through this unit.

The following special activities were also carried out by the council:

1. Public Relations Roundup Conference . . . With the approval of the Board of Trustees, the council sponsored a "Public Relations Roundup Conference" at the Executive Offices on Wednesday, October 26, 1960. To it were invited the executive secretaries and chairmen of public relations committees of component county societies and representatives of the Woman's Auxiliary.

The purpose of the conference was to achieve by informal means a thorough review of public relations activities at county level and to entertain ideas and suggestions for improvement and enlargement of the public relations programs of The Medical Society of New Jersey and its component societies. It was the unanimous sentiment of all who were present that the conference well realized its purpose and, in consequence of the lively exchange and fullness of participation which characterized it, that it was productive of much benefit and advantage to all who participated in it.

Formal presentations were made by selected speakers, and after each presentation lively discussion followed. Among the topics were: (a) Making Our Emergency Medical Call System Work; (b) Basic PR Considerations for Physicians and their Office Personnel; (c) Burlington County Membership Handbook; (d) A Method for the Indoctrination of New Members; (e) The Future Physicians Club. Speakers from the floor dealt with "Ideas and Suggestions for Effective Public Relations," including (a) cooperating with the press; (b) making speakers available; (c) publicizing the judicial mechanism; and (d) projects that have worked in local counties.

2. PR Exhibit at Annual Meeting . . . At the 195th Annual Meeting the council is sponsoring an innovation in the form of an educational exhibit in medical public relations.

The theme of the exhibit is "Medical Public Relations . . . and *You*." The exhibit will be located in the Card Room on the Lobby Floor of Haddon Hall. It is the hope of the council that all our members will visit this exhibit for such advantage as it may supply to them in developing a more complete and comprehensive appreciation of the part that each physician must play for the furtherance of good public relations for Medicine in New Jersey.

Approved (page 387)

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON MEDICAL SERVICES

Industrial Health

(Reference Committee "F")

Willis B. Mitchell, M.D., Chairman, Toms River

During the year the Special Committee on Industrial Health met twice, once in joint session with the Special Committee on Workmen's Compensation.

In keeping with a suggestion of the AMA Council on Occupational Health, the special committee has suggested that its name be changed from "Industrial Health" to "Occupational Health," which designation does not limit by name the work of the special committee to industry alone, but includes also the health problems of other occupations such as agriculture and business. This suggestion was submitted to the Board of Trustees at its April meeting, and the Board tabled the matter for the purpose of investigating further its desirability.

The committee has contacted each component society urging that local committees be established. The component societies have also been informed that the state committee stands ready to act in an advisory capacity on local problems, and the state committee will also suggest names of speakers on industrial and occupational health for local meetings.

Projects for the committee include:

1. To emphasize the need of Tetanus Tox-

oid Immunization in occupations, and to stimulate interest and aid of physicians in this program;

2. To explore the possibilities of presenting an occupational health program at the 1962 annual meeting—program to include both a panel discussion and exhibit; and

3. To study the possibilities of publishing a pamphlet on organization and operation of an industrial health program for distribution in New Jersey, as has been done in Ohio.

Adopted (page 387)

Workmen's Compensation

(Reference Committee "F")

Joseph A. Lepree, M.D., Chairman, Elizabeth

Last year, the Special Committee on Workmen's Compensation recommended to the House of Delegates that consideration be given to "adoption of a schedule whereby cardiac disability in compensation cases can be more readily evaluated." The reference committee recommended, and the House of Delegates approved, "that the special committee conduct a study regarding evaluation of cardiac disability."

In accordance with this action of the House of Delegates, the committee this year devoted its time to studying this problem. The committee was in agreement on the following:

1. The AMA "Guides" should be accepted only as a method of evaluation of physical impairment, and should not be construed as legal evaluation of disability.
2. The AMA "Guides" should be tentatively accepted by the committee as the basis for further investigation.
3. That a joint conference should be held—with representatives from The Medical Society of New Jersey, The New Jersey Bar Association, The State Department of Labor, and insurance carriers—to discuss and try to arrive at an amicable solution to the problem of evaluation of compensation disability in Workmen's Compensation Court, and also the appearance of physicians for testimony in Workmen's Compensation Court.
4. That the next step in the committee's study will be to review the current Workmen's Compensation law with a view toward possibly recommending amendments to the law.

Adopted (page 387)

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Cancer Control

(Reference Committee "G")

John L. Olpp, M.D., Chairman, Englewood

The Special Committee on Cancer Control undertook a survey to determine the number of functioning Tumor or Cancer Registries in the 114 licensed hospitals in New Jersey. The State Department of Health listed 46 operating Cancer Registries. Questionnaires were sent to 44 hospitals with 25 or more beds to learn whether a Tumor Registry was operating or planned. 34 replies were received, and 14 more registries were discovered—a total

of 60 functioning Cancer Registries. 17 hospitals reported they had no registries, and 13 institutions failed to reply. Of the 17 hospitals without registries, 9 are planning to establish them.

The chairman attended a "Cancer Program Workshop," sponsored by the American College of Surgeons, on March 9, 1961, at Temple University Medical School, Philadelphia, Pa. Cancer registries were discussed in general, and then specifically as they related to follow-up and end results reporting. The value of the registry in improved patient management was emphasized. Dr. James B. Mason of the American College of Surgeons stated that 50 per cent of all cancer patients are seen in hospitals of 100 beds or less. The hospital staff committee on cancer is the keystone for an effective cancer program. Beginning in June, 1961, the American College of Surgeons will begin to evaluate the professional care of the patient on a permissive basis. The cancer registry will be a big factor in evaluating the care of cancer patients.

General James Cooney stated that the American Cancer Society is considering support of Cancer Registry Programs and/or Clinical Programs. Financial aid for cancer registries also may be forthcoming from United States Public Health Service funds via the State Health Department.

Recently, the hospitals without cancer registries and those which had not replied to our previous questionnaire were queried as to whether they did or did not have Committees on Cancer. Of the 31 questionnaires sent out, 25 replies were received—5 of the 17 hospitals without registries have Cancer Committees; 3 other hospitals also have committees. This would indicate that 68 hospitals have Cancer Registries or Committees and 17 hospitals have neither.

RECOMMENDATIONS

That the Special Committee on Cancer Control undertake the following program in 1961-62:

1. Discuss with representatives of the State Department of Health the feasibility of instituting a central registry in that Department—the nucleus being the current 60 reporting hospitals with functioning tumor or cancer registries.
2. Study the possibility of standardizing forms to be used in registries and investigate the possibility of a printing subsidy by the United States Department of Health, the New Jersey State Department of Health, and/or the American Cancer Society.
3. Encourage pathologists in non-registry hospitals to support the establishment of a registry because the diagnosis of cancer must be confirmed or verified, and all new cases usually originate in the pathology laboratory or department.
4. Send a questionnaire to the remaining 24 small or specialty hospitals to learn whether they have committees on cancer and/or cancer registries.

Approved (page 388)

Child Health

(Reference Committee "G")

ROBERT E. JENNINGS, M.D., Chairman, South Orange

Two meetings of the Special Committee on Child Health were held during the year, at which attention was given to several matters.

In consideration of a suggestion that a roster of school physicians would be desirable, the special committee recommended that the Secretary of the Society compile and maintain such a roster. In cooperation with the Office of Health, Safety and Physical Education of the New Jersey State Department of Education a roster of public school physicians has been compiled. The committee suggests that this roster be expanded to include school physicians in private and parochial schools in New Jersey.

After several conferences and communications with representatives of the State Department of Education a satisfactory revision of "Recommendations for Pupil Health Examination" was approved by the committee. These

recommendations, prepared and issued by the State Department of Education, include the desired standards for eye and mental health examination as suggested by The Medical Society of New Jersey.

Five papers presented at the April 1960, Symposium on Student Athletic Activities and Prevention of Athletic Injuries were published during the year in THE JOURNAL of The Medical Society of New Jersey.

An exhibit, "The Changing Role of the School Physician," prepared by the special committee, will be presented at the 1961 annual meeting.

The committee has cooperated with the State Department of Education in responding to requests for advice from the Department on "Pep Pills" and items for inclusion in school bus first-aid kits.

The committee has submitted, through the Council on Public Health to the Council on Legislation, suggested amendments to revise the current laws pertaining to working paper examination, and special education services for emotional and maladjusted pupils. The committee has also suggested to the Council on Public Health that the Society recommend a modification to the present ruling of the State Board of Education as to athletic examinations.

During the year, the chairman of the special committee participated in a panel discussion on athletic injuries at the South River High School Parent Teacher Association, and was privileged to represent the Society at the AMA 8th Conference on Physicians and Schools in Chicago.

Approved (page 388)

The Chronically Ill and the Aging

(Reference Committee "G")

WILLIAM H. HAHN, M.D., Chairman, Newark

The committee recommends, as it has in other years, continuing efforts to establish and maintain in each county society an active committee for the care of chronically ill and the aging. To act as coordinating centers for all programs concerning the chronically ill and aging, these should assemble information as to available facilities and needed facilities and should aid in stimulating the development of information and referral centers.

The citizens of New Jersey look to the medical profession for leadership in the health field, and we believe that there is an urgent need for greater community effort under medical direction in extending and improving rehabilitation and restorative services throughout the state. We recommend, therefore, that the component societies direct their attention toward bringing about a more effective community program of rehabilitation and restoration for the chronically ill and the aging.

The committee **recommends** for adoption by The Medical Society of New Jersey, as an expression of policy, the following outline for a program of medical care for the aged:

1. Readoption of realistic attitude toward the aging by encouraging full or partial employment of individuals according to their capabilities and without regard to mere calendar age.

2. Assignment of responsibility for financing of health care in the following order: the individual; the family; local voluntary agencies; local, county, state, and federal government . . . each to take over only when the precedent agent of responsibility cannot meet the need.

3. Promotion of health maintenance through significant constructive activity, proper diet, intelligent exercise and living habits, regular physical checkups, and early detection of disease.

4. Utilization of all restorative and rehabilitative services for the return of the incapacitated to self-care and independent living.

5. Development of community activities for those older people incapable of independent constructive activity.

6. Extension of private voluntary prepayment insurance to effect adequate economical coverage of the aging citizens.

7. Establishment of tax-supported programs—under the Kerr-Mills Bill—adminis-

tered locally, with benefits available to people according to their demonstrated needs.

8. Encouragement of facilities for the care of those incapacitated aging citizens for whom family care is not possible.

9. Dissipation of the concepts that aging is a handicap and the aged a problem, and substitution instead of the realization that aging is a natural process and that the aged are first-class citizens who through their past and present contributions enlarge the general good.

The committee considered the development of a Home Care Program as presented by Curtis Culp, M.D. of the State Department of Institutions and Agencies and acknowledges receipt thereof. On advice of the Council on Public Health, the committee will await the results of a pilot study embodying this program which is presently under way before it submits a recommendation for action by the Society in this regard.

Approved (page 388)

Conservation of Hearing and Speech

(Reference Committee "G")

S. Eugene Dalton, M.D., Chairman, Ventnor

The Special Committee on the Conservation of Hearing and Speech has studied the operation of hearing and speech centers in other states. Experience in Massachusetts, Oregon, etc. indicates that centers for the conservation of hearing and speech can be established and operated satisfactorily through appropriations made available through the State Department of Health assisted by the Special Committee on Conservation of Hearing and Speech, the New Jersey Academy of Ophthalmology and Otolaryngology, and the Division of Maternal and Child Health of the Department of Health. The Special Committee on the Conservation of Hearing and Speech has a program for the establishment and operation of such centers in New Jersey, approved by the Board of Trustees and the House of Delegates, and the committee would like permission to investigate, with representatives of the New Jersey State Department of Health, the possibility of funds being made available for the program through the State Department. The results of such an investigation would, of course, be reported back to the Society, through regular channels, and no commitment would be made by the committee. This would be an exploratory investigation.

If funds become available, screening tests could be conducted under the supervision of the local or regional hospital Speech and Hearing Centers for school children and adults.

A special screening program for pre-school children is suggested to be conducted in cooperation with the Division of Maternal and Child Health of the Department of Health and the New Jersey Chapter of the American Academy of Pediatrics.

It is suggested that all hearing aid fitters and dealers be certified and licensed by the State. In order to qualify for certification these dealers should pass a written and performance examination to insure a minimum degree of competence and knowledge in a number of areas as they relate to the fitting of hearing aids. The law also should forbid unethical advertising or high pressure selling technics.

Approved with deletion of last paragraph, because it is not in the best interest of medical care, nor is it in the best interest of the public itself (page 388)

Conservation of Vision

(Reference Committee "G")

Samuel M. Diskan, M.D., Chairman, Atlantic City

The Special Committee on the Conservation of Vision has had a very busy year, and it has been most encouraging to the chairman to have had the effective cooperation of the committee members in the several conferences and meetings which have been held.

EYE HEALTH SCREENING PROGRAM

This year, for the fourth consecutive year, The Medical Society of New Jersey, under the auspices of the Special Committee on the Conservation of Vision, conducted a state-wide Eye Health Screening Program. The program was aided and supported by the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Department of Health, the New Jersey State Commission for the Blind, and the New Jersey Hospital Association, but it could not have been possible without the invaluable assistance of the Executive Office staff and the support of the Council on Public Relations.

It was conducted in 58 centers, usually local hospitals, during the last week of September 1960, and was manned by 180 ophthalmologists. Approximately 5,500 people were screened, almost half of whom were found to need corrective eye care.

This program is primarily, but by no means exclusively, aimed at the early detection of glaucoma, which in most cases is insidious and slow in onset, often producing irreparable damage before it is detected.

The program, one of our best medical public relations and eye health projects, will again be offered to the public the week of September 25, 1961, on an expanded scale. New Jersey physicians are urged to support this project and are urged to encourage their patients to attend the screening program scheduled in their area.

RECOMMENDATION

That the House of Delegates approve the continuance of this excellent program—scheduled for the week of September 25, 1961.

SCHOOL EYE HEALTH PROGRAM

This committee adopted a program to gain maximum participation and cooperation of all ophthalmologists in order to further plans to improve the supervision of eye health care programs in our public schools. The program will get underway shortly, as soon as the workload on the Executive Office staff subsides to a point where this new program can be worked in.

LICENSURE

The committee withdrew from last year's position requesting the cessation of licensing ophthalmic technicians on the basis that this stand could impair our public relations.

The committee went on record, however, as opposed to future licensure of any segment of ancillary workers in the medical care field as not in the best public interest. Such licensure may be used to control the numbers of workers in a particular field of medicine regardless of the physician's need for the technical help required to practice properly in that field of medical care.

EYE CARE ON FUNDED PAYMENT BASIS

The proposed "Pilot Plan for Eye Care on a Funded Payment Basis" was published in The Journal, and the component societies were polled—as recommended by the 1960 House of Delegates.

The committee reviewed the responses from the counties and the alternate proposals submitted by Essex and Camden counties, both of which alternate proposals the committee disapproved.

The following statement was adopted by the committee as the reasons why the proposed Pilot Plan is disapproved, and why it should be disapproved by the House of Delegates:

> The pilot plan study indicates that medicine and labor can discuss problems. However, medicine already has the means of taking care of these people under established mechanisms. As

is being done by other groups, labor can establish funds to aid patients in meeting their medical bills; such a plan would not be objectionable. The patient would pay the physician directly, and the patient would be reimbursed by labor upon presentation of a receipted bill for services rendered by the physician. Such reimbursement would be in accordance with the allowance provided by the fund.

RECOMMENDATION

That the proposed Pilot Plan for Eye Care on Funded Payment Basis be disapproved by the House of Delegates.

CONTACT LENSES

Upon the request of the Board of Trustees, the committee prepared an opinion on the "Practice of Fitting Contact Lenses" for presentation to the Attorney General.

The opinion concluded that the public health will be served best if the practice of fitting contact lenses is considered proper to the practice of medicine. The decision to prescribe and use contact lenses should not be made lightly and without need. The proper practice of prescribing contact lenses requires careful evaluation, based upon medical history, medical examination, medical diagnostic procedures, and medical treatment; and therefore should be performed by, or under the direction of a fully licensed physician.

RECOMMENDATION

That the House of Delegates support the position that the practice of fitting contact lenses is properly and exclusively an act of medical practice.

OPTOMETRIC STANDARDS

A request for a conference by the New Jersey Optometric Association resulted in an exploration of optometric practices and a decision by the committee to meet on an exploratory basis with optometrists. Standards governing the conduct of the meeting and the use of the material discussed at the conference are prerequisite for the meeting.

Approved (page 388)

Maternal and Infant Welfare

(Reference Committee "G")

JOHN D. PREECE, M.D., Chairman, Trenton

The Special Committee on Maternal and Infant Welfare has continued its work of collecting, analyzing, and classifying the maternal death reports throughout the state in cooperation with the Division of Maternal and Infant Welfare, New Jersey State Department of Health.

Information from the meetings, which is judged to be valuable or essential to maternal welfare, will be distributed to the county committees through their Field Physicians.

This same type of material will also be submitted to THE JOURNAL of The Medical Society of New Jersey for publication. It is felt that, in this way, the value of the studies of maternal deaths can be utilized by a larger group of practicing physicians.

Approved (page 389)

Mental Health

(Reference Committee "G")

John J. Mackin, M.D., Chairman, Jersey City

The Special Committee on Mental Health met three times during the year and submitted three reports to the Council on Public Health. The following items were considered:

STATE PROGRAM FOR THE CARE OF ALCOHOLICS

As directed by the Board of Trustees last year, the Special Committee on Mental Health met with the Commissioners of the State Department of Health and the State Department of Institutions and Agencies to discuss the State Program for Care of Alcoholics. The following conclusion was reached:

> We believe that the present limited State Alcoholism Program is being satisfactorily administered. For a future complete program of general hospital care for the acute alcoholic, follow-up care and treatment of family groups, contacts with other agencies to further the welfare of the alcoholic, we recommend that a psychiatrist should be in charge of the program whether it is conducted by the State Department of Health or by the Division of Mental Health of the State Department of Institutions and Agencies.

The above conclusion was amended by the Board of Trustees—"we recommend that a psychiatrist . . ." was amended to read "we recommend that a *licensed doctor of medicine* . . ."— and the amended conclusion was approved by the Board and transmitted to the two Commissioners.

The State Program was considered in part by the Council on Public Health, particularly as regards those hospitals which receive funds to maintain out-patient clinics for alcoholics but which refuse to provide in-patient facilities which are so necessary. It was the unanimous agreement of the special committee that hospitals which do not provide in-patient treatment of alcoholics should receive financial assistance for out-patient treatment of alcoholics, provided such hospitals do not restrict their admissions because patients are alcoholics and agree to accept those alcoholics whom they are equipped to treat. The special committee also unanimously agreed that financial assistance for out-patient alcoholics should be denied to those hospitals which refuse to treat in-patient alcoholics whom they are equipped to treat.

REPORTING OF EPILEPSY CASES

The Advisory Council of the New Jersey Consultation Service for Convulsive Disorders concluded that accurate statistical data can best be obtained through a survey conducted under the auspices of, and with the approval of, or in cooperation with members of, The Medical Society of New Jersey. The special committee discussed this conclusion of the present Advisory Council and agreed that it was in accord that evidence seemed to indicate that the present method of reporting epileptic cases was not as adequate as should be and was, therefore, unsatisfactory. For this reason the special committee favored consideration of the repeal of the law making mandatory the reporting of epilepsy cases. The special committee also approved the principle of the Medical Society's cooperating in any way possible with the Advisory Council in terms of a survey. However, it emphasized that approval of any survey would be contingent upon proof that the survey was scientifically sound and served a necessary, useful purpose. At the present time there is no survey as such to review, nor was the special committee convinced that a survey, as proposed, would be any more accurate than the present method of reporting cases of epilepsy.

It was the action of the Board of Trustees that the Society should not take action for repeal of the law which makes epilepsy a reportable disease, but rather that the Society should take steps to encourage enforcement of the law. If the law were effective, the statistics would be available and a survey would be unnecessary.

ENTERTAINMENT HYPNOSIS

At the direction of the Board of Trustees, in compliance with the request of the Council on Legislation, the special committee was assigned the responsibility of providing effective reasons justifying proposed legislation to prohibit Entertainment Hypnosis. A member of the special committee, Dr. George A. Rogers, made a detailed study and research of the subject. The committee unanimously

adopted with commendation Dr. Rogers' report and referred it to the Board of Trustees. The following statement on the purpose of the proposed legislation was adopted by the committee and submitted to the Board also:

> It is harmful to subjects, having resulted in anxiety states, in depression, and psychosis, and also dangerous of poorly applied posthypnotic suggestion. The wrong impression that the public gains as a result of watching entertainment hypnosis makes application of hypnosis in its proper medical place difficult. Legally, there is a great deal of precedent for outlawing entertainment hypnosis. References supporting all of the above are available.

RELATIONS OF MEDICINE AND PSYCHOLOGY

The special committee reviewed and discussed a circular letter sent out last summer by the Essex County Society of Clinical Psychologists in Private Practice. The letter, announcing the availability of a membership directory, was received by a member-physician of a local medical society. It is the opinion of the committee that true knowledge of all the differences in the fields of psychiatry, psychology, and social work are not generally known and understood by the majority of medical men. A statement on the relations of medicine and psychology—approved by the AMA Board of Trustees, the Council of the American Psychiatric Association, and the Executive Committee of the American Psychoanalytic Association—was approved by the committee and has been offered for publication in The Journal of The Medical Society of New Jersey.

Representing the special committee and the Society, the chairman attended the following meetings during the year:

1. Joint meeting of representatives of the Society, the New Jersey State Bar Association, and the New Jersey Neuropsychiatric Association—on the subject of criminal responsibility of the mentally ill and the mentally deficient.
2. Symposium at the Edward R. Johnstone Training Center, Bordentown, where the mentally retarded are treated.
3. Symposium on hypnosis at Rutgers University, sponsored by the Society for Experimental Hypnosis.
4. AMA 7th Annual Conference on Mental Health, Chicago. Discussion group subjects included: mental hospitals, psychiatric trends in general hospitals, mental health services for children, out-patient psychiatric clinics, general rehabilitation services, and medical-legal aspects of commitment. Reports of the panel groups and general discussion followed. The program was very informative and beneficial. At this meeting there was also a presentation of plans for the first AMA National Congress on Mental Health—probably to be held in late 1961 or early 1962. It is hoped and suggested that The Medical Society of New Jersey be represented at this national meeting when it is held.

Approved (page 389)

Rehabilitation

(Reference Committee "G")

Elmer J. Elias, M.D., Chairman, Trenton

The Special Committee on Rehabilitation convened on three occasions during the year to determine the progress being made to obtain financial aid toward the compilation of a Directory of Rehabilitation Facilities in the State of New Jersey. It had been previously recognized that the services of one or two medical social workers would be necessary to initiate and bring the project to a successful completion.

As of this time it can be definitely stated that funds are not available from the Office of Vocational Rehabilitation. However, this does not mean that support may not be obtained at a later date after the project has been started.

Information has been received that the estimated cost of a full time qualified project director, well experienced in this type of work, would be $10,000 per year. The actual time

required to compile a Directory of Rehabilitation Facilities would depend on the cooperation received from the county Committees on Rehabilitation. Also the extent of the surveys as noted in those conducted in Minnesota, Washington, Maryland, and Virginia—would be a deciding factor for the time required to complete the project.

At a recent meeting of the New Jersey Conference of the Handicapped, it was learned that a similar project—compilation of a directory—utilizing full time workers will be initiated. Since the project of the Special Committee on Rehabilitation of The Medical Society of New Jersey has been made known to the New Jersey Conference of the Handicapped, it is hoped that a minimal amount of reduplication of effort will be exerted, and that there will be a free exchange of data collected between the two groups.

RECOMMENDATIONS

1. That the House of Delegates authorize the appropriation of $10,000 to the Special Committee on Rehabilitation for use in defraying the cost of full time personnel required to compile a Directory of Rehabilitation Facilities in the State of New Jersey.

(Note: The 1960 House of Delegates approved the report of the committee which stated "if funds are not available from this source—Office of Vocational Rehabilitation—then the committee intends to recommend that the project be undertaken by The Medical Society of New Jersey.")

At its April meeting the Board of Trustees voted disapproval of recommendation number one for the reason that it would be duplication of service since the information is available through the counties and through some state agencies.

2. That the Committee on Rehabilitation in each component society be requested to cooperate in collecting the desired material and information for its respective county.

Approved with exception of recommendation #1; #1 DISAPPROVED in accordance with the comment and reasons given by the Board of Trustees (page 389)

SPECIAL COMMITTEES

Physicians Placement Service

(Reference Committee "D")

SAMUEL J. LLOYD, M.D., Chairman, Trenton

The Physicians Placement Service maintains current lists of communities in the state in need of additional physicians. These lists are forwarded to all physicians interested in establishing a practice in New Jersey. Names and pertinent data of those registering with the Placement Service are also compiled into lists which are forwarded to interested municipal authorities, to practicing physicians seeking assistants or associates, to industries, and to the various divisions of the State government employing medical personnel. In addition, during the past year requests were received from five sources in the New England area—two hospitals and three civic community groups—which were attempting to locate medical personnel not procurable within their immediate areas. The Placement Service cooperated with these groups by making available to them its current listing of physicians seeking locations.

Inquiries received during 1960-61 from physicians interested in establishing a practice in New Jersey		375 (100%)
Referred by the A.M.A.	128 (34%)	
Direct inquiries	247 (66%)	
Located in New Jersey		44 (12%)
Located elsewhere		111 (30%)
Dropped from list because of failure to respond to follow-up communications		139 (37%)
On active list as of 4/10/61		81 (21%)

The heaviest demand made upon the Service is for general practitioners who will be available within a relatively short period of time. Unfortunately, most of the available physicians wish to enter the various specialty fields.

All clerical procedures necessary to operate and maintain this program are assigned to the various members of the Executive Office staff as part of their regular duties.

Approved (page 385)

Traffic Safety

(Reference Committee "H")

A. M. K. Maldeis, M.D., Chairman, Camden

During the year the members of your committee have attended numerous meetings and conferences in furtherance of the business of the committee. On November 22, 1960, the Chairman attended a conference, called by the Attorney General of the State of New Jersey, dealing with the determination of alcohol levels in the blood of all those involved in fatal motor accidents in which the victims are sixteen years of age or over.

A conference was held at the request of the Division of Motor Vehicles whose representatives sought help in dealing with a problem confronting the Division. Present at the conference, held at the Society Headquarters, November 16, 1960 were: Mr. Schwoebel and Mr. Sherwood, representing the Division; Mr. Nevin, Dr. English and the Chairman of this committee. The representatives from the Division stated that they had no physicians on their staff, and felt the need of a panel of impartial medical specialists to whom a questionable applicant or driver could reliably be referred for determination, on the basis of dependable scientific evidence, as to his capability to operate a motor vehicle without danger to himself or others. For further consideration of this matter a second meeting was held on January 5, 1961, at the Medical Society Headquarters. Mr. Parsekian, Director of the Division of Motor Vehicles, and Deputy Director Schwoebel were present by invitation. The Committee suggested a plan which was received by the Division for study. It is expected that an acceptable plan of medical assistance to meet the needs of the Division will very shortly be worked out.

The Chairman of this committee, upon request of the President of the Medical Society, represented the Society at two meetings of the New Jersey Safety Council in Newark. These meetings were very instructive and gave a clearer idea of the all-embracing activities of the Safety Council.

The Committee feels that progress has been made during the year toward increased traffic safety, in view of the cooperative attitude manifested by the representatives of the Division of Motor Vehicles in the course of conferences and considerations with them.

Accepted (page 389)

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1961 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

ATLANTIC COUNTY

Carl A. Surran, Margate; age 71

BERGEN COUNTY

Lloyd B. Whitman, Pompano Beach, Fla. (formerly Bergenfield); age 67

CAMDEN COUNTY

Roberto Principato, Camden; age 72

ESSEX COUNTY

Katherine V. Mauer-Alden, St. Thomas, V. I. (formerly East Orange); age 55
James S. Allan, Millburn; age 72
William Ehrlich, South Orange; age 55
John Pois, Camarillo, Calif. (formerly South Orange); age 59
A. Alba Rubin, East Orange; age 60

MORRIS COUNTY

George W. Comeau, Morris Plains; age 64

PASSAIC COUNTY

Francis W. Ash, Paterson; age 70
Alvin E. Cortese, Paterson; age 62
Sante M. Giambra, Paterson; age 65
Gay B. Kim, Paterson; age 65

UNION COUNTY

Rowland P. Blythe, Cranford; age 69
George W. H. Horre, Elizabeth; age 67
John E. Runnells, Scotch Plains; age 85

WARREN COUNTY

Frank A. Wolf, Sr., Phillipsburg; age 73

Accepted (page 389)

SUPPLEMENTAL NOMINATIONS

The following supplemental nominations for election to emeritus membership at the 1961 Annual Meeting were received from the component society, too late for inclusion in the published list. The nominees are now and have been members in good standing for at least twenty years, and by reason of health have retired from the active practice of medicine. All are emeritus members of their respective component societies.

BERGEN COUNTY

A. Ivan Mader, Wayne; age 57
Aloysius F. Padden, Oradell; age 54

Accepted (page 389)

PROPOSED AMENDMENTS TO CONSTITUTION AND BYLAWS

Proposed Amendment to the Constitution

(Reference Committee on Constitution and Bylaws)

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1960 Annual Meeting, recognizing that such amendment must be considered by the House of Delegates for final vote in 1961. In compliance with the Constitutional provision regarding amendments, the proposal was sent to each component society and published in THE JOURNAL in January 1961.

ARTICLE VI — BOARD OF TRUSTEES

(second paragraph)

Current	Proposed
From and after May 21, 1953, any member may be elected a Trustee for a maximum of three (3) full terms, provided, however, that if the first two (2) elected terms are successive, there shall be a lapse of one (1) year between expiration of the second and commencement of the third term. The term of any Trustee commencing prior to May 21, 1953, shall not be included in the limitation of three (3) elected terms.	Any member may be elected a Trustee for a maximum of three (3) full terms.

Adopted (page 392)

Proposed Amendments to the Constitution and Bylaws

(Reference Committee on Constitution and Bylaws)

From the Union County Medical Society
Co-sponsored by the Cumberland, Middlesex,
and Ocean County Medical Societies

The following proposed amendments to the Constitution and Bylaws, as submitted in writing by the Union County Medical Society, were transmitted to the Committee on Constitution and Bylaws and to each component society in January 1961—in accordance with the provisions of Article XII of the Constitution and Chapter XII of the Bylaws.

CONSTITUTION

ARTICLE VI — BOARD OF TRUSTEES

Current

The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the then incumbent.

Proposed

(underlined words are amendments)

Section 1 — Composition

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Each County shall be entitled to at least one (1) Trustee and for the larger counties they shall be entitled to one (1) Trustee for each five hundred (500) active or voting members or fraction thereof as of December 31 of each year. Each Trustee shall be elected from and by his component county society prior to the annual meeting of the House of Delegates. The term of office shall be three (3) years and such term shall commence upon the expiration of the term of the former incumbent. The term of office of one third (1/3) of the elected Trustees shall terminate annually.

Section 2 — Procedure

Provided that at the first election following the adoption of these amendments, the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect one Trustee from each county for one year, the second seven (7) counties, from Gloucester through Morris, shall elect one (1) Trustee from each county for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect one Trustee from each county for three years. Counties with more than one (1) Trustee shall elect them on a staggered basis, for one (1), two (2), and three (3) years. Thereafter at the expiration of these terms each Trustee shall be elected for a full term of three (3) years.

Section 4 — Filling Vacancies

In the event that the office of any member becomes vacant for any reason the component county society wherein the vacancy exists shall elect a member within ninety (90) days to fill the unexpired term.

At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

DELETE entire paragraph

Defeated [split vote, 127 to 220] (page 391)

BYLAWS

Proposed for Voting in 1962

CHAPTER V — PROCEDURE OF ELECTION

Section 1 — Nominating Committee

Current	Proposed
(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the nominating committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.	(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the nominating committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations but excluding Trustees.

Not adopted (page 391)

CHAPTER VI — RIGHTS AND DUTIES OF OFFICERS

Section 5 — Board of Trustees

(a) Organization. At the first meeting of the Board of Trustees, following each annual meeting of the House of Delegates, the Board	(a) Organization. At the first meeting of the Board of Trustees, following each annual meeting of the House of Delegates, the Board

of Trustees shall organize by electing a chairman and secretary. The chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the chairman, but any four (4) Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Nine (9) Trustees shall constitute a quorum.

of Trustees shall organize by electing a chairman and secretary. The chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the chairman, but any four (4) Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Eighteen (18) Trustees shall constitute a quorum.

Not adopted (page 391)

RESOLUTIONS

1

Board Memberships

(Reference Committee "A")

From the Mercer County Medical Society

1. AGE LIMIT

Resolved, that no member of the Board of Trustees of The Medical Society of New Jersey, Board of Medical Examiners of New Jersey, or Board of Trustees of Medical-Surgical Plan of New Jersey shall continue in office after he has completed his seventieth year of age.

2. CONCURRENT MEMBERSHIPS

Resolved, that no member of The Medical Society of New Jersey shall be permitted to serve in more than one of the following categories at the same time: Board of Trustees of The Medical Society of New Jersey, State Board of Medical Examiners of New Jersey, or Board of Trustees of Medical-Surgical Plan of New Jersey.

COMMENT BY BOARD OF TRUSTEES

The above resolutions were received by the Board of Trustees, at its meeting on February 19, 1961, —"for the information of the Board of Trustees with the request that they be referred to the House of Delegates of The Medical Society of New Jersey for action at its next meeting." By action of the Board the resolutions are referred to the House of Delegates with a recommendation for disapproval. The reasons of opposition are:

1. The resolutions would be dictatorial to the Governor in limiting his power of appointment to the State Board of Medical Examiners in accordance with the regulations of the Medical Practice Act.

2. The resolutions could be construed as illegal directions inasmuch as the composition of the State Board of Medical Examiners and the Board of Trustees of Medical-Surgical Plan is in accordance with law.

3. It is advantageous to this Society, its members, and the Board to have someone to carry from one high-level to the other high-level an official understanding of the point of view of the Society, its members, and the Board.

4. The Board of Trustees of the Medical Society formulates and promulgates general policy, and presence of Society Board members on the other boards will help both to illuminate and express such policy to the advantage of both the Society and the other agencies.

5. Finally, the nature of the contribution to be made by a well-qualified member of a board or other governing body will not necessarily be adversely affected by the fact that a man passes his seventieth birthday. It is the position of organized medicine that, in justice, mere calendar age should not arbitrarily debar an otherwise competent individual from rendering continuing service.

Disapproved, in accordance with the comment and reasons given by the Board of Trustees (page 382)

2

AMA Dues Increase

(Reference Committee "B")

From the Nebraska State Medical Association

Whereas, the American Medical Association is in need of an immediate, continuous, and positive all-out Public Information campaign conducted by an outside agency specializing in this field, and

Whereas, the House of Delegates of the American Medical Association will be asked to approve a $20.00 increase in dues in June, 1961, therefore be it

Resolved, that the Nebraska State Medical Association does not approve this increase in dues if the above indicated campaign is not initiated and carried out at once, and be it further

Resolved, that this increase in dues shall be reviewed in three years, and cancelled if unnecessary for the purpose for which it was initiated, and be it further

Resolved, that a copy of the resolution be distributed at once as follows: (1) Board of Trustees, American Medical Association; (2) for introduction into the House of Delegates of the American Medical Association; (3) every state medical society; and (4) all county societies in the United States in large metropolitan areas.

(Received and filed as part of the annual report of the Board of Trustees without prejudice for the information of the House of Delegates.)

Recommendation ADOPTED that Resolution #2 be supported by the New Jersey Delegates to the AMA (page 383)

3

Journal and Emeritus Members

(Reference Committee "B")

From the Camden County Medical Society

Whereas, The Medical Society of New Jersey at present discontinues the sending of its JOURNAL to Emeritus Members upon their election to said status except upon their personal subscription to THE JOURNAL, therefore be it

Resolved, that THE JOURNAL of The Medical Society of New Jersey be distributed to Emeritus Members of The Medical Society of New Jersey at no cost whatsoever to such members, and be it further

Resolved, that this resolution be presented for consideration at the next meeting of the House of Delegates of The Medical Society of New Jersey.

Adopted (page 383)

4

Future Physicians Clubs

(Reference Committee "E")

From the Essex County Medical Society

Whereas, the quality of applicants to American Medical Colleges has declined in the past few years and this fact is attested to by the Deans of Admission, the Association of American Medical Colleges, and the AMA, and

Whereas, it is to our own interest to assume leadership in maintaining a continued quality in our ranks, and

Whereas, it is well known that medicine is now losing a large share of talented prospects to other professions because other fields are now actively recruiting in our high schools and colleges and a great number of students are wooed and won by the promise of early rewards after a shorter education, and

Whereas, the AMA at its June 1960 Annual Meeting resolved "That the American Medical Association, through its component state medical associations, and the various county medical associations, present medicine's story to the high schools of the nation in person," and

Whereas, the organization of Future Physicians Clubs under the leadership of County Medical Societies is an effective means of implementing a Future Medical Careers Program, and

Whereas, the Future Physicians Club of the Essex County Medical Society has received overwhelming support from science-minded high school students, their school faculties, the deans of local medical colleges, the Association of American Medical Colleges, and the Public Relations Department of the AMA; therefore be it

Resolved, that The Medical Society of New Jersey request the AMA to recommend that all County Medical Societies consider taking leadership in this field by organizing local Future Physicians Clubs for the purpose of recruiting talented and dedicated students for medical careers, and be it further

Resolved, that the American Medical Association adopt this as a national project.

Approved, but with deletion of the final "Resolved" as superfluous (page 387)

5

Social Security for Physicians

(Reference Committee "E")

From the Mercer County Medical Society

Whereas, results of polls by State Medical Societies and independent organizations clearly demonstrate that a substantial majority of the nation's self-employed physicians desire to be included under the Social Security program; and

Whereas, members of the House of Delegates of the AMA have continued to oppose Social Security coverage at AMA annual and clinical meetings despite the overwhelming evidence that a majority of the medical profession wants it; and

Whereas, Congress has been reluctant to enact a law to include physicians under Social Security in view of the AMA House of Delegates' opposition to such legislation; and

Whereas, unless the AMA House of Delegates changes its attitude and begins to reflect the real wishes of the majority of physicians on this issue, physicians and their families

will continue to be the only professional group in the nation that is deprived of the protection and benefits of the Social Security program; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey recommend that the New Jersey members of the House of Delegates of the AMA present a resolution at the next meeting of the AMA requesting the AMA to support favorable action on Social Security for physicians, indorsing their inclusion in its benefit; and be it further

Resolved, that the Mercer County Component Society hereby instructs its delegates to the annual meeting of The Medical Society of New Jersey to introduce a resolution in that body, making it binding on all elected members of the AMA House of Delegates from our State to vote for Social Security coverage at the national AMA meetings.

Substitute Resolution #18 ADOPTED as embodying the intent of Resolutions #5, #6, and #13
(Page 387)

6

Social Security for Physicians

(Reference Committee "E")

From the Passaic County Medical Society

Whereas, results of polls by State Medical Societies and independent organizations clearly demonstrate that a substantial majority of the nation's self-employed physicians desire to be included under the Social Security program; and

Whereas, members of the House of Delegates of the AMA have continued to oppose Social Security coverage at AMA annual and clinical meetings despite the overwhelming evidence that a majority of the medical profession wants it; and

Whereas, Congress has been reluctant to enact a law to include physicians under Social Security in view of the AMA House of Delegates' opposition to such legislation; and

Whereas, unless the AMA House of Delegates changes its attitude and begins to reflect the real wishes of the majority of physicians on this issue, physicians and their families will continue to be the only professional group in the nation that is deprived of the protection and benefits of the Social Security program; therefore be it

Resolved, that the Passaic County Medical Society hereby instructs its delegates to the annual meeting of The Medical Society of New Jersey to introduce a resolution in that body, making it binding on all elected members of the AMA House of Delegates from our State to vote for Social Security coverage at the national AMA meetings.

Substitute Resolution #18 ADOPTED as embodying the intent of Resolutions #5, #6, and #13
(page 387)

7

Relative Value Index

(Reference Committee "F")

From the Camden County Medical Society

Whereas, the grimness of a Relative Value Index set loose in New Jersey harbingers no factual solace for patient or doctor and borders on questionable medical morals and ethics; and

Whereas, it is so much naivete to believe that RVI is not a fee schedule—a schedule which hovers perilously close to fixation by third-party manipulation; and

Whereas, the practice of medicine has scarcely a breather in its fight for sanctity of freedom; and

Whereas, a physician is responsible only to his patient and not yet completely obligated to covenants between indemnifiers and said patient; and

Whereas, appalling unrealism is manifested by this attempt at standardization of illness, patient, doctor, and the very art of medicine; and

Whereas, the sanguine "Trust" (avowed by doctors themselves) of a comparative value of procedures would be forever on the hands of The Medical Society of New Jersey, while the flexible "Conversion Factor" may be sinisterly flexed by insurance companies, union health plans, and government as well as by the doctor; and

Whereas, once we accept the dictation of a Relative Value Index, we would relinquish personal and individual responsibility with overt invitation to controlled practice; and

Whereas, many instances of dour and doleful results have already been recorded in areas where a similar plan has been extant; therefore be it

Resolved, that the Camden County Medical Society go on record as unalterably opposed to the Relative Value Index which forebodes more ill than good for physicians of New Jersey; and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey, and that it be considered by the 1961 House of Delegates, and that a copy of this resolution be sent to each component society in advance of the 195th annual meeting of the parent body.

No action since matter deferred until next meeting of House of Delegates, annual or special (page 388)

8

Influenza Immunization Campaign

(Reference Committee "G")

From the Passaic County Medical Society

Whereas, the polyvalent influenza vaccine has proved its efficacy and is the only defense against the epidemic disease, influenza, and

Whereas, several public and semi-professional institutions and agencies are sending out directives urging immunization against influenza, and

Whereas, there is already a tendency on the part of public agencies to distribute free vaccine, and

Whereas, the American Medical Association in the case of the anti-poliomyelitis campaign issued a directive to all the State medical societies and these in turn to their constituent county societies, and

Whereas, the anti-influenza campaign is

primarily a medical problem and our medical organizations should take the initiative and give leadership, therefore be it

Resolved, that the Passaic County Medical Society, through its representatives, urge The Medical Society of New Jersey, and through it the American Medical Association, to evaluate and give leadership to the anti-influenza campaign similar to the campaign against poliomyelitis.

Approved (page 389)

SUPPLEMENTAL RESOLUTIONS

9

MSP-HSP Joint Rider for Diagnostic Services

(Reference Committee "C")

From the Board of Trustees

Whereas, in compliance with a directive of the House of Delegates, representatives of the Medical Society met with representatives of the New Jersey Hospital Association—in an attempt "to evolve a method of payment by Blue Shield for diagnostic x-ray and diagnostic pathology done in the out-patient department of the hospital at the direction of the attending physician"—*but without success;* and

Whereas,—likewise in compliance with a directive of the House of Delegates—a special committee of the Society met with the Commissioner of Banking and Insurance in an effort to induce him not to approve the request of the Hospital Service Plan of New Jersey for a separate rider to cover the above enumerated services, *but again without success;* and

Whereas, the Hospital Service Plan of New Jersey has deferred action to effectuate a separate rider for diagnostic services pending the action of this House of Delegates concerning the acceptability of a joint rider; therefore be it

Resolved, that this House of Delegates re-evaluate its position concerning the acceptability of a joint rider; and be it further

Resolved, that this House of Delegates approve in principle the issuance of a joint rider by Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey provided that:

1. Such joint rider be available only to subscribers holding basic contracts with both Medical-Surgical Plan and Hospital Service Plan.
2. Such joint rider offer the subscriber the option—at the choice and direction of the treating physician (other than a physician employed by, or under contract with, a hospital)—to utilize the rider benefits under either Medical-Surgical Plan or Hospital Service Plan.
3. All the details of coverage and cost of the joint rider have the formal, official approval of the Board of Trustees of The Medical Society of New Jersey and the Board of Trustees of Medical-Surgical Plan of New Jersey.
4. Upon official agreement to issue such joint rider, the Hospital Service Plan withdraw its application for a separate rider for diagnostic services, and agree in writing not to take steps toward the establishment of any such separate rider during the continued existence and operation of said joint rider above referred to.

Report and resolution APPROVED with the request that the Board of Trustees submit to the presidents of the component societies for their information the formal joint rider as drafted (page 384)

10

HSP Maternity Benefits

(Reference Committee "C")

From the Hudson County Medical Society

Whereas, the Hospital Service Plan of New Jersey was founded to take care of patients' hospital bills for catastrophic illness; and

Whereas, since its foundation many additional benefits have been added by the Plan; and

Whereas, hospitalization for pregnancy and its complications can be very costly; therefore be it

Resolved, that The Medical Society of New Jersey recommend to the Hospital Service Plan that the seven (7) day limitation for maternity services be modified so that patients will not be discriminated against by reason of their pregnancy, and so that pregnancy with a complication will be granted the usual number of days as for other conditions.

Approved (page 384)

11

Relation of Medicine to Optometry

(Reference Committee "G")

From the Mercer County Medical Society

Be it resolved, that the Mercer County Component Medical Society go on record requesting the House of Delegates of The Medical Society of New Jersey propose that the New Jersey Delegates to the American Medical Association be instructed to introduce a resolution at the next meeting of the American Medical Association, requesting the appointment of a commission on the relation of medicine to optometry. At least half of the members shall be practicing ophthalmologists. The function of this commission shall be to conduct a broad study from the standpoint of public interest, exploring all possible and desirable solutions to problems which concern medicine as related to optometry. This commission shall report its findings to the House of Delegates of the American Medical Association not later than June 1962.

Content APPROVED, but Resolution #14 ADOPTED as it is in more detail (page 389)

12

Riders for Diagnostic Services

(Reference Committee "C")

From Daniel B. Roth, M.D., Delegate from Bergen County

Resolved, that The Medical Society of New Jersey affirm and support the issuance of a rider for x-ray and laboratory services by the Medical-Surgical Plan of New Jersey; and be it further

Resolved, that The Medical Society of New Jersey reject and express its disapproval of any efforts by the Hospital Service Plan of New Jersey—either alone or in conjunction with the Medical-Surgical Plan of New Jersey—to issue riders to cover x-ray and laboratory services under Blue Cross policies; and be it further

Resolved, that this Society express its continued opposition to all efforts by third parties, be they hospitals, insurance companies, or any others, to enter into the practice of medicine under any guise whatsoever.

Paragraph 3 ACCEPTED (page 384)

13

Social Security for Physicians

(Reference Committee "E")

From the Sussex County Medical Society

Whereas, it has been clearly demonstrated by repeated polls by State Medical Societies and other organizations that the majority of the Nation's self-employed physicians desire to be included under the Social Security Program; and

Whereas, the members of the House of Delegates of the American Medical Association have continued to resist the Social Security coverage at its annual and clinical meetings; and

Whereas, the Congress of the United States has as yet failed to enact a law to include physicians under Social Security; and

Whereas, the real desires of the majority of physicians, on this issue, are repeatedly ignored; therefore, be it

Resolved that the House of Delegates of The Medical Society of New Jersey recommend to its members of the House of Delegates of the American Medical Association that a resolution be presented at the next American Medical Association meeting, requesting the American Medical Association to reverse its attitude and support favorable action on Social Security for Physicians; and be it further

Resolved that the Sussex County Component Medical Society hereby instruct its delegates to The Medical Society of New Jersey annual meeting, to introduce this resolution in that body, making it binding on all elected members of the American Medical Association House of Delegates from our State, to vote for Social Security coverage, at the next annual meeting of the American Medical Association.

Substitute Resolution #18 ADOPTED as embodying the intent of Resolutions #5, #6, and #13 (page 387)

14

Relation of Medicine to Optometry

(Reference Committee "G")

Submitted to the Board of Trustees by the Essex County Medical Society (without prejudice) and transmitted by the Board of Trustees to the House of Delegates

Whereas in 1959 there was introduced in the AMA House of Delegates Resolution #31 calling for the establishment of a Commission to Study the Relation of Medicine to Optometry, and to report to the AMA House of Delegates, and

Whereas, the AMA House of Delegates caused to be established a Subcommittee to Study the Relation of Medicine to Optometry, under the then Joint Committee to Study Paramedical Areas in Relation to Medicine, and

Whereas, the original Joint Committee to Study Paramedical Areas in Relation to Medicine has been succeeded by the Committee on Relationships of Medicine with Allied Health Professions and Services, and

Whereas, optometrists are not ancillary to medicine, but are independent licensed practitioners, and therefore do not constitute an allied health profession, and

Whereas, there exists confusion in the public mind as to the distinction between medical care for patients with ocular complaints and optometric services, and

Whereas, the lack of understanding in this area is a threat to the welfare of the patient, therefore be it

Resolved, that the AMA House of Delegates establish a Commission on the Relation of Medicine to Optometry, to be appointed by the Speaker of the House; at least half the members of which Commission shall be physicians practicing in the ophthalmic branch of medicine, and be it further

Resolved, that it shall be the specific function of this Commission to conduct a broad study, from the standpoint of the public interest, of the problems involved in the present relation of medicine to optometry, and to explore all possible and desirable solutions to these problems, and be it further

Resolved, that the AMA Board of Trustees be requested to provide adequate personnel and funds for the proper performance of the duty assigned to this Commission, and be it further

Resolved, that this Commission shall report to the AMA House of Delegates not later than June 1962.

NOTE: (Resolution adopted by the Tennessee State Medical Association April, 1961)

Adopted (page 389)

15

Medical Corporations or Associations

(Reference Committee "E")

From the Mercer County Medical Society

Whereas, tax sheltered pensions and/or Social Security may yet be ours if we can be permitted to form a medical corporation or association; and

Whereas, the American Medical Association has devised a model corporation or association which permits three or more physicians to group themselves together for the practice

of medicine, and which model was adopted by the States of Arkansas and South Dakota; bringing the number of states permitting this to 15; and

Whereas, the Internal Revenue Service allows corporations or associations thus formed and meeting certain requirements, such as continuity of life, etc., to withdraw fifteen to twenty per cent of income before taxes to be placed in pensions or retirement funds for the members of the corporation or association so formed, therefore be it

Resolved, that the Retirement Committee of The Medical Society of New Jersey be continued in office and investigate the possibility of obtaining the revision of the appropriate laws of the State of New Jersey permitting the formation of medical corporations or associations.

Approved (page 387)

16

Assistant Secretary of Defense (Health and Medical)

(Reference Committee "F")

From the Bergen County Medical Society

Whereas, the position of Assistant Secretary of Defense (Health and Medical) has been abolished and the matters pertaining to that Office have been placed under the Assistant Secretary of Defense for Manpower, and

Whereas, medical care of the military forces personnel is a Department of Defense responsibility subject to accomplishment only when the key medical officer is directly responsible to the Secretary of Defense for the fulfillment of a fully coordinated Medical Service position, and

Whereas, the people of the United States of America regard the health and welfare of their defense personnel of prime importance, and hold in such high esteem the dignity of man that the military medical forces have in the past decade established the world's most outstanding military medical achievements in world-wide military and civilian operations, and

Whereas, the subordination of the professional representative in liaison between military medicine and the Secretary of Defense is not in the best interest of the people of the United States, its Armed Forces, or its military medical program, therefore be it

Resolved, that the Bergen County Medical Society, Component Society of The Medical Society of New Jersey, strongly recommends the re-establishment of the position of Assistant Secretary of Defense (Health and Medical) and that a copy of this resolution adopted by the Bergen County Medical Society at its Annual Meeting on May 9, 1961, be presented for adoption by the House of Delegates of The Medical Society of New Jersey and by its Delegates to the House of Delegates of the American Medical Association for adoption and forwarding to the President of the United States and the Secretary of Defense.

Adopted (page 387)

17

Nurses' Recruitment

(Reference Committee "A")

From Irving Levitas, M.D., Delegate from Bergen County

One of the main problems of many hospitals today is the recruitment of nurses for nursing schools, and as far as we have been able to determine in our Hospital Committee, there's been very little the Medical Society itself has done in relationship to studying this entire problem.

So I would like to offer a resolution:

That The Medical Society of New Jersey study the problem of nursing education from the standpoint of recruitment especially and put this thing into the proper committee so that we can have liaison with the State Hospital Association which is going to have a similar resolution in order to study the entire problem.

Approved, with the recommendation that the President of the Society appoint a Special Committee on Nursing Education to study and make recommendations (page 382)

18

Social Security for Physicians

(Substitute for resolutions No. 5, No. 6, and No. 13)

From Reference Committee "E"

Whereas, the members of the House of Delegates of the American Medical Association have continued to oppose the compulsory inclusion of physicians under Social Security; and

Whereas, the Congress of the United States has not as yet enacted a law to effect such inclusion; and

Whereas, this House of Delegates in 1959 approved inclusion of physicians of New Jersey under Social Security; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey recommend to its A.M.A. delegates that a resolution be introduced at the next meeting of the American Medical Association recommending the extension of Social Security to include physicians; and be it further

Resolved, that the delegates of The Medical Society of New Jersey to the American Medical Association be clearly mandated to support this resolution or any other favoring the inclusion of physicians under the Social Security program.

Adopted (page 387)

Medical Service Administration of New Jersey

(Reference Committee "C")

ROYAL A. SCHAAF, M.D., President, Board of Governors

During 1960, the activities of Medical Service Administration of New Jersey have been concerned with the City of Newark Medical Plan and the Medicare Program of the United States Government.

NEWARK MEDICAL PLAN

The Newark Medical Plan provides for medical services in the homes of eligible persons by physicians of the patient's choice on a fee-for-service basis. If a patient does not have a family physician, a telephone call to the Newark Division of Health at any hour, day or night, will bring a physician to the home of the patient within a short time.

The Newark Plan is designed to meet the needs of the indigent and medically indigent on a "cost plus," rather than on an insurance basis. It is a prime example of how the problem of public medical care for this class of patient may be successfully solved through the cooperation of an official health agency with a voluntary non-profit agency established by the medical profession.

The statistics below present the experience of the Plan over a five-year period from 1956 to 1960 inclusive. (amounts from 1944 to 1955 are listed in previous reports)

The classification of *indigent* is applied to those persons whose names appear on the welfare rolls of the City of Newark; the *medically indigent* are those who are considered by the City Division of Health as having sufficient income to meet the routine of an adequate standard of living, if this income is insufficient to pay for needed medical care.

The drop between 1959 and 1960 of approximately 600 in the mean average number of cases on the welfare rolls of Newark is attributed to the absorption by the Essex County Welfare Board of the "Aid to Dependent Children" cases; these formerly were given temporary assistance by the City of Newark Welfare Division on an emergency basis of two or three months until they were accepted by the State Board of Child Welfare. All told, 1560 "welfare" cases were closed during 1960. However, due to the current recession with its consequent unemployment, the Welfare Division anticipates a great increase in 1961, having picked up over 500 cases between December 1960 and February 16, 1961.

Forty-two physicians participated in the program during 1960.

The Essex County Medical Society has cooperated by supplying new physicians to the panel available to serve the needy of the City of Newark on a twenty-four hour basis.

The Plan has operated smoothly with no change in procedure or policy in the past year.

INDIGENT (RELIEF) PERSONS

YEAR—	1956	1957	1958	1959	1960
Mean number of persons on Welfare Rolls during year	3883	4262	6626	7026	6431
Number of cases served	1277	1556	1655	2154	1654
Value of approved services	4,6 15.00	$ 7,000.50	$ 7,630.00	$10,791.00	$ 7,417.00
Cost per capita of relief load	1.19	1.57	1.15	1.50	1.15
Cost per case per year	3.60	4.54	4.61	5.00	4.48

MEDICALLY INDIGENT CASES*

Number of cases served during year	2993	4291	3703	3425	2553
Value of approved services	$ 9,969.00	$17,662.50	$15,420.00	$16,439.00	$11,979.00
Cost per case per year	3.33	4.11	4.16	4.80	4.69

*The word "case" here means "family" as distinguished from "person" referred to under the report on number of "persons" on Welfare Rolls above.

MEDICARE PROGRAM

As the "fiscal agent" for The Medical Society of New Jersey, Medical Service Administration completes its fourth year of administration of the physicians' part of the Medical Care Program for dependents of members of the armed services. This was first implemented by the Department of the Army on December 7, 1956. Under this program, known briefly as "Medicare," wives (or dependent husbands) and children of persons in active military service, qualify for medical, surgical, obstetrical and hospital services rendered by civilian physicians and hospitals at the expense of the Federal government. The experience gained in the first three years of our operation of the Program accounts for the smooth and efficient system of handling claims.

During 1960, only two informational releases were sent to physicians adding to and modifying the Medicare Program—surely an indication of the stabilization of the provisions which regulate the Program.

A review of the accomplishments of the Medicare Program in New Jersey since its inception in December 1956 is presented below.

It will be noted that of the 7,925 physicians' claims received in 1960, 2,384, or more than 31 per cent have had to be returned as incomplete or incorrect. Reason for the greatest number of claims returned is the misinterpretation by physicians of MSA Bulletin 54 (September 30, 1960) which concerns billing for maternity cases. Many physicians bill $100 for a delivery without indicating the "to date," or *final postpartum treatment date*—ordinarly six weeks following delivery. Therefore payment is reduced to $95—the fee for delivery excluding antepartum or postpartum care. By the simple procedure of indicating on his DA 1863 Medicare claim form the dates "from" and "to" during which care was rendered in maternity cases, a physician's claim can be swiftly adjudicated. He will then receive payment for his services without undue delay and endless correspondence.

1,482 New Jersey physicians received fees for services performed for beneficiaries of the Medicare Program during 1960. This compares with 1,770 during 1959; 2,005 during 1958; and 1,675 during 1957.

Of the claims paid in 1960 about 70 per cent were for maternity care, 6 per cent for adult surgery, and 6 per cent for miscellaneous medical services; the remaining 18 per cent represented care to children. Of this, 12 per cent was for general pediatric and medical care, and 6 per cent for pediatric surgery.

In New Jersey, dependents of *Army* personnel represented approximately 35 per cent of the total number of cases; and those of the *Navy* about 33 per cent; and of the Air Force about 20 per cent. The Marine Corps, Coast Guard, Public Health Service and Coast Geodetic Survey—the remaining classes of the armed services whose dependents are eligible for Federal Medicare coverage—accounted for the remainder.

Physicians' claims increased 7 per cent over that of 1959, due mainly to the restoration (after January 1, 1960) of benefits which had been classified as ineligible since October 1958.

At this point it might be well again to review some of the benefits which were restored.

RESTORATION OF RESTRICTED BENEFITS

Effective January 1, 1960, certain of the benefits that were curtailed in October 1958 by Congressional action were restored as follows:

Dependents residing apart from sponsor (the

CLAIM EXPERIENCE

Period	Received	Declined	Returned As Incomplete	Paid Claims	Paid Amount	On Hand
Dec. 7, 1956 - Dec. 31, 1957	10,017	320	3,179	5,982	$489,265	356
Jan. 1, 1958 - Dec. 31, 1958	14,014	377	3,758	9,298	778,551	1084
Jan. 1, 1959 - Dec. 31, 1959	7,384	385	1,972	5,908	494,691	206
Jan. 1, 1960 - Dec. 31, 1960	7,925	197	2,384	4,930	413,329	610
TOTAL	39,340	1,279	11,293	26,118	$2,175,836	610

uniformed serviceman) will continue to be allowed selection of either uniformed services facilities or civilian medical sources for care under the Program.

Dependents residing with sponsor will continue to utilize an available uniformed services facility in the area in which residing. When such facilities are not available, a "permit"—form 1251—will be furnished such dependents by the commander authorizing them to seek medical care from civilian sources. The issuance of this "permit" places the dependent *residing with sponsor* in essentially the same "free choice" position as a dependent residing apart from sponsor. The permit is limited to immediate use in a current illness, injury or condition.

Surgical services that may be planned or elected, which, in the opinion of the physician in charge, are medically indicated.

Out-patient care, including diagnostic and therapeutic tests and procedures authorized by the attending physician, but limited to treatment of fractures, dislocations, lacerations, and other wounds as prescribed in the "Schedule of Allowances."

Acute emotional disorders constituting emergency in-hospital treatment will be payable when the acute emotional disorder becomes a threat to the life or health of the patient.

These services are subject to certain exceptions detailed in our Bulletin MSA-B-52 which was distributed to the physicians of New Jersey on December 22, 1959.

ADMINISTRATIVE EXPENSE

Period	Amount	Per Case
Dec. 7, 1956-June 30, 1957	$19,670	$11.44
July 1, 1957-June 30, 1958	28,796	3.21
July 1, 1958-June 30, 1959	31,983	3.77
July 1, 1959-June 30, 1960	17,383	3.74
July 1, 1960-Dec. 31, 1960	6,824	2.96
TOTAL	$104,656	

The table above reflects the initial costs accrued in promulgating the Program in New Jersey (contract negotiations, printing, distribution of manuals, and training), and the subsequent additional costs resulting in connection with printing and distribution of new manuals and Schedule of Allowances incurred by the curtailment of benefits in October 1958. The $2.96 figure for the last six months of 1960 is another reflection of the administrative stabilization of the Program.

MEDICARE CONTRACT RENEWAL

A modification, renewing and extending the Medicare contract to June 30, 1961, was executed by The Medical Society of New Jersey and Medical Service Administration of New Jersey with the United States Government, Department of the Army, under date of July 1, 1960.

Subsequently, Medical Service Administration of New Jersey, as "fiscal administrator," renewed the subcontract with the Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the Prime Contract, which services are being performed in the name of Medical Service Administration of New Jersey.

SCHEDULE OF ALLOWANCES

The Schedule of Allowances for services performed under the Medicare Program was negotiated by the Special Medicare Committee of The Medical Society of New Jersey with the Department of the Army. There have been no changes in the current Schedule of Allowances which became effective in October 1958, and in which the agreed-upon-fees compare favorably with those provided by the Medical-Surgical Plan of New Jersey for similar procedures.

PROVISIONS FOR ADJUSTMENTS OF FEES

If a physician believes he is entitled to a fee in excess of that provided under the Schedule of Allowances, he may submit a Special Report to Medical Service Administration. This report is then referred to the Special Medicare Committee of The Medical Society of New Jersey for review and recommendation. The Committee's recommendation is then returned to Medical Service Administration, which, in turn, submits it together with the physician's claim to the Federal Government for consideration. Notification of the amount approved for payment by the Federal Government is then forwarded to Medical Service Administration for remittance to the physician.

Special commendation should be accorded to the members of the Special Medicare Committee of The Medical Society of New Jersey

for their careful and conscientious consideration of each case submitted to them for review and recommendation. Practically without exception, the Office for Dependents' Medical Care in Washington, D. C. has concurred in the recommendation of the Committee.

ELDERCARE PROGRAM

In May 1959 the Board of Trustees of The Medical Society of New Jersey suggested that Medical Service Administration be utilized as an agency to process payments to physicians for a State Public Medical Care Plan. A letter was accordingly sent to Governor Meyner in September 1960. Its purpose was to offer the services of Medical Service Administration to the State for the administration of the Eldercare Program. The latter, by enactment of H. R. 12580 by the 86th Congress, authorized the Federal Government to pay a 'medical percentage' of all State costs for medical assistance on behalf of aged individuals whose resources are insufficient to meet the costs of necessary medical services. Subsequently, representatives of Medical Service Administration and Hospital Service Plan met with the Commissioner of the Department of Institutions and Agencies to discuss further the services which Medical Service Administration might be able to offer the State in the administration of the Eldercare Program. The meeting produced the following salient points:

1. The Department did not know at that time the amount of money that would be available to them for the Eldercare Program—therefore they were not in a position to make any definite commitments.
2. The Department understood and was well acquainted with the principles of Medical Service Administration through meetings held in past years.
3. The Department made it clear that it will retain the authority for determining eligibility of beneficiaries as to need. The Commissioner conceded, however, that his Department would not be interested in administering the claims for benefits for individuals who had been determined by his agency as eligible recipients for Eldercare benefits.
4. Although it was too early for any concrete decision, as the promulgation of the program in New Jersey required legislative action, the Commissioner had no objection to the participation of Medical Service Administration in administering the program, if such were possible.

COMMENT

Medical Service Administration of New Jersey has demonstrated to the physicians of New Jersey its importance and value. Its successful operation of the City of Newark Medical Plan on a Municipal level, and the Medicare Program on a Federal level, amply supports its desirability as an arm of The Medical Society of New Jersey. As a medium through which medical and surgical care may, by arrangements with governmental agencies at Federal, State or other levels, be made to individuals and groups who might otherwise be unable to obtain protection against illnesses on a non-profit voluntary prepayment basis, Medical Service Administration has won the acceptance of the medical profession and the public which it serves. Moreover, it is designed to preserve and enhance the basic tenets upon which the medical profession has always insisted it shall retain—no interference in patient-physician relationship and free choice of physician and patient.

The Board of Govennors of Medical Service Administration of New Jersey again wishes to express to The Medical Society of New Jersey its appreciation of and thanks for the continued moral and financial support so generously given to the Administration throughout the twenty years of its existence.

Approved (page 384)

Medical-Surgical Plan of New Jersey

(Reference Committee "C")

Royal A. Schaaf, M.D., President, Board of Trustees

Message from the President on behalf of the Board of Trustees of Medical-Surgical Plan

On the following pages, a factual presentation of the achievements of Medical-Surgical Plan of New Jersey, New Jersey Blue Shield Plan, for the year 1960, is set forth by the Plan's management and Board of Trustees for the information of members of the medical profession. With several of the items thus presented, considerable satisfaction may be felt by all concerned.

The Plan set an all-time record for benefits during 1960, incurring $31,516,019 in claims for care of subscribers and their dependents, thus exceeding the 1959 volume by just over $1.6 million. Since the Plan was organized under auspices of your Medical Society of New Jersey in 1942, benefits of well over $200 million have been paid for more than two million cases.

We also report with satisfaction a new record for volume of service, with 326,933 cases during 1960, or nearly 15,000 more than in the previous year.

A third milestone achieved during 1960 was attainment of the 2-million mark in Blue Shield membership. At year's end, enrollment had reached 2,080,582, a gain of more than 126,000 over the 1,954,215 on the rolls at the close of 1959. The gain enabled the Plan to maintain its standing as seventh largest of the nation's 69 Blue Shield plans . . . and amply demonstrated that New Jersey residents continue to regard Blue Shield as an outstanding value in health protection.

The year also was marked by availability, for the first time, of Blue Shield initial enrollment to persons aged 65 and over. An estimated 100,000 such "senior citizens," or about 20 per cent of New Jersey residents who are 65 and over, now enjoy Blue Shield protection.

Another high mark reached by Blue Shield during the year was in the number of participating physicians who contract to accept the Plan's fees as payment in full for eligible services rendered to members whose income is under generous limits. The continuing wholehearted cooperation of our participating physicians, incidentally, is a basic reason for the success of the Plan and we are grateful for it. During the year, 177 doctors became participants, bringing the total to a record 6,387, or approximately 8 out of every 10 practicing in the state.

Earned subscriptions of $32,090,542 during 1960 also represented a record, the increase being principally due to the membership growth. Subscription income exceeded incurred claims by $574,523 but operating expenses of $2,777,374 . . . or 8.7 per cent of subscription income . . . led to an underwriting loss of $2,202,851.

Income on investments of $426,365 and an adjustment in non-admitted assets of $29,444 gave the Plan a net loss for the year of $1,747,042, and brought Blue Shield's reserves down to $6,885,000 as compared with $8,632,042 at the end of 1959 and $11,006,985 at the end of 1958.

The necessity of invading reserves to the extent of well over $4 million in two years, in order to meet current obligations to our subscribers, demonstrates clearly why Blue Shield had to apply for a rate increase late in the year. (Incidentally, in March of 1961 Banking and Insurance Commissioner Charles R. Howell granted permission to increase subscription rates an over-all average of 53 cents per month.)

Claims data for 1960, as compared with previous experience, present an interesting pattern in members' usage of Blue Shield benefits. In 1958, for example, 153 of every 1,000 persons enrolled received benefits. The rate rose to 165 in 1959, but increased only to 166 in 1960.

The cost per case average in 1958 was $88.68, rising to $95.24 in 1959, but decreasing to $92.96 in 1960. The principal site of this decline was in the area of surgical cases, with an average cost of $89.13 in 1960 as compared with $92.56 the previous year, while the total number of cases in that category rose from 191,272 to 202,233. The average cost of medical and maternity cases remained virtually constant.

Aside from these statistical milestones, the year 1960 was notable for considerable activity by the Plan in the field of public affairs. Inquiry

into Plan policies and procedures by representatives of organized labor, the Legislature, the Department of Banking and Insurance, and others interested in the economics of health care, required our Management and Trustees to present positively the Blue Shield position in several controversial matters.

With the splendid support of The Medical Society of New Jersey, and employing an intensified program of public relations as a principal weapon, the Plan has striven mightily to combat such legislation as might be deemed harmful, and to promote that which would redound to the benefit of the Plan, its subscribers, and the profession which it serves. At this writing, the future remains beclouded . . . but whatever transpires in the field of regulation and legislation, the profession is assured that its Blue Shield Plan will have "fought the good fight" with every resource at its command.

In closing, may I once more express sincere appreciation for the cooperation and loyalty of the medical profession . . . the devoted and efficient work of our operating staff . . . and, to the Hospital Service Plan of New Jersey, our renewed thanks for continuing service in Blue Shield matters.

Organized 1942

MEDICAL-SURGICAL PLAN OF NEW JERSEY

COMPARATIVE STATEMENT

as of December 31

ASSETS

	1960	1959
Cash	$ 20,700	$ 182,061
Accounts Receivable—Subscriptions	514,926	530,449
Accounts Receivable—Hospital Service Plan	137,648	190,953
Accounts Receivable—Other	367,131	28,249
Accrued Interest and Dividends Receivable	102,079	111,112
Investments	12,694,494	13,634,121
TOTAL ASSETS	$13,836,978	$14,676,945

LIABILITIES

Payable for Medical-Surgical Claims	$ 5,600,000	$ 4,756,000
Unearned Subscriptions	1,247,535	1,231,583
Other Liabilities	104,443	57,320
TOTAL LIABILITIES	$ 6,951,978	$ 6,044,903

RESERVES FOR THE PROTECTION OF SUBSCRIBERS

Securities Evaluation	$ 380,000	$ 336,000
Special Contingency	100,000	100,000
Unassigned	6,405,000	8,196,042
TOTAL RESERVES	$ 6,885,000	$ 8,632,042
TOTAL LIABILITIES AND RESERVES	$13,836,978	$14,676,945

ANNUAL STATISTICS 1960

TABLE I.

PAID 1960

	Services				
	Primary Services	Total Services	% (All Services)	Payment	%
Surgical	202,233	244,191	46.5%	$15,814,217	52.0%
Medical	80,001	95,513	18.2	6,048,867	19.9
Obstetrical	44,699	46,419	8.8	5,503,317	18.1
Consultation	—	31,370	6.0	485,519	1.6
Anesthesia	—	108,120	20.5	2,539,038	8.4
TOTAL	326,933	525,613	100.0%	$30,390,958	100.0%

TABLE II.

AVERAGE PAYMENT PER PRIMARY SERVICE (Service)—Paid 1960

Surgical	$ 78.20
Medical	75.61
Obstetrical	123.12
Consultation	(15.48)
Anesthesia	(23.48)

Note: Tables I and II do not include Federal employee claims.

TABLE III.

DISTRIBUTION OF EARNED SUBSCRIPTION INCOME

		%
Earned Subscription Income	$32,090,452	100.0
Incurred Claims	$31,516,019	98.2
Surgical	16,346,884	50.9
Medical	6,326,080	19.7
Obstetrical	5,706,714	17.8
Consultation	503,463	1.6
Anesthesia	2,632,878	8.2
Operating Expense	2,777,374	8.7
Decrease in Reserve	2,202,851	(6.9)

DISTRIBUTION PER DOLLAR OF INCOME

	Cents
Surgical	50.9
Medical	19.7
Obstetrical	17.8
Anesthesia	8.2
Consultation	1.6
Operating Expense	8.7
Total of above	106.9
Withdrawn from Reserve	-6.9
	$ 1.00

TABLE IV.

PERCENTAGE DISTRIBUTION OF EARNED INCOME

	%
Incurred Claims	98.2
Operating Expense	8.7
Withdrawal from Reserve	(6.9)

ADDITIONAL CLASSIFICATION OF INCURRED CLAIMS BASED ON DISTRIBUTION OF PAID CLAIMS FOR 1960

Total Incurred 1960	$31,516,019	98.2%
Surgical	$16,346,884	50.9
Medical	6,326,080	19.7
Obstetrical	5,706,714	17.8
Consultation	503,463	1.6
Anesthesia	2,632,878	8.2

INCIDENCE RATE PER 1000 PERSONS ENROLLED

1942	40
1945	86
1948	96
1951	112
1954	126
1956	143
1958	153
1959	165
1960	166

CLAIMS INCURRED

Year	Claims (to nearest $100)
1942	$ 5,400
1945	208,300
1948	1,203,600
1951	6,527,000
1954	13,992,000
1956	18,961,000
1958	25,038,000
1959	29,916,000
1960	31,516,000

ENROLLMENT GROWTH

Year	Enrollment (to nearest 100)
1942	4,000
1945	50,000
1948	237,000
1951	670,000
1954	1,197,000
1958	1,830,000
1959	1,954,000
1960	2,081,000

COMPARATIVE SUMMMARY OF OPERATIONS

		1960	Per Cent		1959	Per Cent
Subscriptions Earned		$32,090,542	100.0		$29,631,426	100.0
Less:						
Claims Incurred	$31,516,019		98.2	$29,916,007		101.0
Operating Expenses	2,777,374		8.7	2,545,431		8.5
		34,293,393	106.9		32,461,438	109.5
(Loss) from Underwriting Operations		$(2,202,851)	(6.9)		$(2,830,012)	(9.5)
Income on Investments		426,365			443,571	
Operating (Loss) for the Year		$(1,776,486)			$(2,386,441)	

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1	$ 8,632,042	$11,006,985
Operating (Loss) for the Year	(1,776,486)	(2,386,441)
	$ 6,885,556	$ 8,620,544
Plus: Change in Non-Admitted Assets	29,444	11,498
Reserves at December 31	$ 6,885,000	$ 8,632,042

HIGHLIGHTS OF PLAN OPERATIONS 1960 - 1959

Subscriptions Earned by the Plan Increased in 1960 over 1959 by	$ 2,459,116
Subscribers' Claims Incurred by the Plan Increased in 1960 over 1959 by	1,600,012
Operating Expenses Increased in 1960 over 1959 by	231,943
In addition, based on Subscriptions Earned, 1960 showed a percentage increase of	.2%
Reserves for the Protection of the Plan's Subscribers (Decreased) in 1960 under 1959 by	$(1,747,042)

NEW JERSEY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

COUNTY	PARTICIPATING M.D.	D.O.	D.S.C.	Total	NON-PARTICIPATING M.D.	D.O.	D.S.C.	Total Eligible Phys.	% P.P. As of 12-31-60	% P.P. As of 12-31-59
Atlantic	175	19	11	205	17	—	—	222	92.3	90.4
Bergen	541	50	29	620	274	13	—	907	68.3	68.7
Burlington	109	18	8	135	21	4	—	160	84.3	83.8
Camden	315	84	19	418	56	4	1	479	87.2	88.2
Cape May	42	6	3	51	4	2	—	57	89.4	87.5
Cumberland	98	4	7	109	3	1	—	113	96.4	95.2
Essex	1235	52	74	1361	293	11	—	1665	81.7	82.8
Gloucester	69	11	7	87	11	5	—	103	84.4	82.6
Hudson	559	10	36	605	133	1	—	739	81.8	81.9
Hunterdon	55	1	—	56	3	—	—	59	94.9	94.3
Mercer	329	6	13	348	63	6	—	417	83.4	85.3
Middlesex	274	9	14	297	66	—	—	363	81.8	83.4
Monmouth	283	16	14	313	63	2	—	378	82.8	83.2
Morris	225	14	7	246	52	3	—	301	81.7	80.9
Ocean	85	5	2	92	12	—	—	104	88.4	86.5
Passaic	403	13	28	444	133	4	2	583	76.1	77.4
Salem	45	4	2	51	3	1	—	55	92.7	96.5
Somerset	96	2	3	101	20	—	—	121	83.4	85.0
Sussex	36	2	2	40	3	1	—	44	90.9	87.5
Union	441	24	35	500	187	4	1	692	72.2	69.7
Warren	44	2	—	46	2	—	—	48	95.8	90.1
Out of State	149	16	—	165	—	—	—	165	—	—
Totals	5608	368	314	6290	1419	62	4	7775	80.9	81.2

1960 BOARD OF TRUSTEES

Charles W. Barkhorn, M.D.	1952
Irving P. Borsher, M.D.	1950
Robert G. Boyd	1957
Charles L. Cunniff, M.D.	1958
Joseph P. Donnelly, M.D.	1953
Joseph 1. Echikson, M.D.	1954
Jerome G. Kaufman, M.D.	1959
Joseph M. Keating, M.D.	1953
Samuel J. Lloyd, M.D.	1958
Arthur W. Lunn	1951
Paul Mecray, Jr., M.D.	1953
Duane E. Minard, Jr.	1957
Glennis S. Rickert, M.D.	1959
Royal A. Schaaf, M.D.	1942
Rudolph C. Schretzmann, M.D.	1945
James H. Spencer, M.D.	1957
Edward W. Sprague, M.D.	1942
John S. Thompson	1942
Thomas J. White, M.D.	1951
†Carl K. Withers	1952

The President of The Medical Society of New Jersey serves as a Board member during his term as President.

ADVISORS TO THE BOARD OF TRUSTEES

		Term as Board Members
Harry N. Comando, M.D.	1959	1942-1958
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952
Elton W. Lance, M.D.	1951	1942-1951

Appointment Year shown after name.

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
†Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
†William J. Carrington, M.D.	1942-1943
†Patrick H. Corrigan, M.D.	1952-1958
†Samuel A. Cosgrove, M.D.	1944-1953
†William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
†Augustus S. Knight, M.D.	1942-1948
†Thomas K. Lewis, M.D.	1942-1949
†Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951

†Deceased.

PHYSICIAN RELATIONS PROGRAM

During 1960, the Physician Relations Section of Medical-Surgical Plan drew closer to its goal of maintaining and improving the "two-way street" of cooperation between the Plan and its Participating Physicians.

The number of personal contacts with physicians made by the Plan's Field Representatives increased in 1960 over those made in 1959. One of the major features of this program is the scheduling of at least one visit a year with medical staffs of general hospitals throughout the state. This is accomplished by pre-arrangement with Administrators and Chiefs of Staff of individual hospitals for the establishment of an information desk in the doctors' lounge or by an invitation to address a Medical Staff meeting.

The primary purpose of this program is to disseminate Plan policy and to advise physicians of current changes in rules and regulations and in the Schedule of Maximum Plan Payments. The representatives also invite questions from physicians in an effort to assist them in solving problems which arise in the course of their individual dealings with the Plan.

In 1960, the total number of contacts made by the Physician Relations Section was 3,751. This represents an increase of more than 900 over those made in 1959. The total number of hospitals visited in 1960 was 78, an increase of 10 over the preceding year.

The response from physicians to our Field Program has been gratifying. The medical staff of each of the 78 hospitals visited in 1960 has welcomed the program as evidenced by their cooperation in the scheduling of these meetings. The genuine interest shown by individual physicians during the course of each meeting is further evidence of the relative success of the program.

We earnestly hope that each contact made during 1960 helped in some small way to improve the liaison between the Plan and the medical profession.

Approved (page 384)

SUPPLEMENTAL REPORT

RIDERS FOR DIAGNOSTIC SERVICES ETC.

Since the annual report of Medical-Surgical Plan of New Jersey was submitted, there have been important developments in connection with riders: those now being sold by Medical-Surgical Plan; a separate rider now filed by Hospital Service Plan with the Department of Banking and Insurance and the proposed concurrent or joint rider of Medical-Surgical Plan and Hospital Service Plan—all three to provide payment for diagnostic pathological laboratory services, diagnostic x-ray services, radiation therapy and physical therapy in physicians' offices outside of hospital, or in hospital out-patient departments.

In order that all members of The Medical Society of New Jersey may be fully informed of the present status of the three riders the following summary indicating the status of each is submitted:

1. Medical-Surgical Plan Rider A became effective July 1, 1959 and has been offered for sale since that date except for a brief period. The persons now covered by this Rider number approximately 100,000. After 18 months' experience, certain deficiencies became apparent, and were the cause of complaint by various groups, based on the unavailability of privately operated x-ray and pathological laboratories. As a result, and at the request of the Plan, the Department of Banking and Insurance approved a voluntary reduction in the Rider rate of approximately 36 per cent.

2. A separate rider which has been developed by Hospital Service Plan of New Jersey has been approved by and filed with the Department of Banking and Insurance. However, this rider has not been offered for sale, pending action by the House of Delegates of The Medical Society of New Jersey relating to the proposed issuance of a concurrent or joint rider by both Plans. We have been assured that if the joint rider is made available the Hospital Service Plan will not sell its independent rider. Moreover, we have been assured that the separate rider of Hospital Service Plan will not be sold to individuals.

3. At the present time the concurrent or joint rider (hereinafter called joint rider) is in draft form only, and several of its provisions may need change or clarification, notably the elimination of possible duplicate coverage by both Plans in equal amounts. After conference with the Department of Banking and Insurance, we confidently expect that a single premium may be collected for the joint rider, with the premiums received to be deposited in a separ-

ate account from which payments will be made to physicians and/or hospitals, as the case may be. This procedure will assure that the total payments to be made either to physicians and/or hospitals will not exceed the maximum amounts stipulated in the present Blue Shield Rider A for pathological laboratory services, diagnostic x-ray services, radiation therapy and physical therapy. Under such a joint rider, the referral of patients for the services included therein will be completely at the discretion of the attending physician.

A final decision by the Trustees and the House of Delegates of The Medical Society of New Jersey is urgently needed in the matter of the joint rider, as the Hospital Service Plan of New Jersey, under pressure by the New Jersey Hospital Association and enrolled groups, will be obliged to offer its separate rider for sale if a joint rider is not to be made available in the near future. Were this to eventuate, Medical-Surgical Plan Rider A would soon become unsalable and would require abandonment.

The Trustees of Medical-Surgical Plan therefore **recommend** that the Trustees and House of Delegates of The Medical Society of New Jersey approve in principle the development and sale of a joint rider by Medical-Surgical Plan and Hospital Service Plan. It is further **recommended** that approval of the content of the joint rider be delegated to the Board of Trustees of The Medical Society of New Jersey, with the understanding that the Trustees shall be satisfied that the content of the joint rider adequately protects the interests of the physician as well as the Subscriber.

PUBLIC RELATIONS COUNSEL

In accordance with the recommendations of the Board of Trustees of The Medical Society of New Jersey, the Plan engaged its own Public Relations Counsel. Mr. Franklin H. Romaine was employed as a Public Relations Officer of the Plan commencing May 1, 1961. Mr. Romaine will be paid by and be responsible exclusively to Medical-Surgical Plan. Activities involving joint public relations with Hospital Service Plan will be coordinated with the existing Public Relations Department of Hospital Service Plan.

Approved (page 384)

ADDENDUM TO SUPPLEMENTAL REPORT

At a conference with the Department of Banking and Insurance, held on May 11, 1961 with representatives of Medical-Surgical Plan and Hospital Service Plan, the Department approved the principle of a Blue Shield-Blue Cross Joint Rider having a single premium rate for the common benefits proposed under the Joint Rider. The Department further agreed that the limits for the common benefits in such rider, will be in the same amounts as limited in the current Blue Shield Rider A.

The tentative monthly rates allocated to the *common benefits* proposed under the Joint Blue Shield-Blue Cross Rider are as follows:

Single	$ .59
Parent and Child	1.03
Husband and Wife	1.66
Family	1.72

Approved (page 384)

REFERENCE COMMITTEE REPORTS

Reference Committee "A"

Dorsett L. Spurgeon, M.D., Chairman

The reference committee met on Sunday, May 14, at 11:00 a.m., with all members present, namely: Drs. Norman K. Boudwin, Thomas F. Flynn, Jr., J. Bruce Henriksen, Clement M. Jones, and Dorsett L. Spurgeon. There were approximately 25 members present during the meeting to discuss the various reports.

Report of the **President** (page 305)—This report was carefully reviewed, and approved by the reference committee. The committee wishes to call attention to the amount of work the President has given, including many meetings and many miles of travel, and wishes to thank Dr. McCall for all the time and effort he has expended in behalf of the Society this year.

Adopted

Report of the **Secretary** (page 307)—This report was thoroughly reviewed and approved. It is to be noted that the Society now has a total membership of 6,275 active members and 392 associate members—with only 5,775 of these being members of the American Medical Association, which gives us six delegates to the A.M.A. Also the report comments on the 5th edition of the *Membership Directory*, now in preparation, and calls attention to the fact that any change for the directory must be in before June 1. The committee commends Dr. Greifinger on his good work.

Adopted

Report of the **Board of Trustees** (page 312)—The report was reviewed in detail, and approved. We wish to thank the Board members for their diligence in behalf of the Society this year.

In the section on *Communication between the Board and Component Societies* (page 312), there were suggestions from the floor that, on invitation, trustees from each judicial district might attend county society meetings more often in an attempt to keep them more informed on state level procedures.

The supplementary report from the Board of Trustees on the court decision in the case of *Falcone vs. Middlesex County Medical Society* (page 317) was reviewed and discussed quite extensively by the members present and the Society's legal counsel, Robert M. Backes. The committee accepted the report, and noted that the Board later will report to county societies and the membership concerning further developments.

Adopted

Report of the **Executive Officer** (page 324)—This report was reviewed and approved. It indicates the extent of activity of our Society through this office, and we wish to commend Mr. Nevin for the excellence of his efforts. The committee calls to the attention of all members of the Society his comments concerning the welfare state and the job each individual physician could do in countering some of this movement. We **recommend** and urge that each member of the Society make special effort to read the report of the Executive Officer.

Adopted

Report of the **Judicial Council** (page 320)—This report was reviewed and approved as submitted. The committee recognizes, with thanks, the amount of time and effort this Council has given to its work.

Adopted

Report of the **Credentials Committee** (page 328)—This report was reviewed and approved. Your reference committee commends the Credentials Committee for its good work.

Adopted

Nurses' Recruitment—Resolution #17 (page 370)—This resolution—presented by a member of the Bergen County Medical Society—was reviewed and lengthily discussed. The committee approves this resolution and **recommends** that the President of the Society appoint a special committee on Nursing Education to study and make recommendations.

Adopted

Board Memberships—Resolution #1 (page 360)—This resolution—from the Mercer County Medical Society—was diaspproved by the committee, in accordance with the comment and reasons given by the Board of Trustees.

Adopted

Reference Committee "B"

Henry O. von Deilen, M.D., Chairman

Reference Committee "B" met in Room 1344 at 11:00 a.m., May 14, 1961. Present were Dr. Henry O. von Deilen, chairman; Dr. Paul J. Kreutz, and Dr. Floyd D. Gindhart. Messages were received from the other two members—Dr. John J. Torppey and Dr. Joseph M. Keating—that they could not attend, and they were excused.

1. Report of **Treasurer** (page 309)—The annual report of the Treasurer, Dr. Daniel F. Featherston, was the first order of business. The committee wishes to compliment Dr. Featherston on a job well done and on his excellent answers to the questions asked in the meeting.

The committee **recommends** that the report of the Treasurer be approved as submitted.

Adopted

2. Report of the **Committee on Finance and Budget** (page 328)—The committee reviewed the report of the Committee on Finance and Budget, under the chairmanship of Dr. David B. Allman. The budget was reviewed in its entirety, and we wish to compliment Dr. Allman on an excellent report and for his continued service to the Society in the preparation of this report.

However, we would like to **recommend** that there be a break-down or explanatory footnotes on any items showing a marked difference between current and proposed budget items.

Adopted

The reference committee approved the recommendations of the Committee on Finance and Budget and **recommends** their adoption by the House. These recommendations are:

(1) That the per capita level of contribution to AMEF for 1962 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Your reference committee **recommends** that the AMEF contribution for 1962 be $5.00 per capita.

Adopted

(2) That the budget for 1961-62 be adopted in the total sum of $218,799.00.

Adopted

(3) That the 1962 assessment be adopted at $35.00 per capita with no provision for a contribution to AMEF.

Adopted

3. **Committee on Medical Student Loan Fund** (page 334)—The reference committee approved the action of the Board in authorizing the transfer to Medical Student Loan Fund, on loan without interest, of all monies in excess of $100,000 in the surplus account at the end of the current fiscal year; the full amount thus assigned to be placed at the disposal of the committee for 1961-62.

Adopted

The reference committee **recommends** that the House reaffirm its action of 1959 "that all members of the Society think of this fund as a philanthropy to which they judiciously contribute"; and it further **recommends** that the component societies intensify their efforts to increase the fund due to the increasing demands being made of it.

It is further **recommended** that future reports of the Committee on Medical Student Loan Fund include a break-down of the loans granted—by county of residence and by medical school attended.

We **recommend** that the report of the Fund committee be approved.

Adopted

4. **Committee on Publication** (page 335)—We commend the Committee on Publication for its continued excellent financial status and the fact that it continues to operate on its own income.

On the recommendations of the committee concerning liquor and contraceptive advertisements, the reference committee **recommends** that such advertisements not be accepted at this time.

Defeated

5. **Resolution #2—AMA Dues Increase** (page 361)—The reference committee **recommends** that this resolution—received as information from the Nebraska State Medical Association—be supported by the New Jersey Delegates to the AMA.

Adopted

6. **Resolution #3—Journal and Emeritus Members** (page 361)—This resolution was approved by the reference committee, and its adoption by the House is **recommended.**

Adopted

7. **Personal Business Property Tax Law** (page 318)—This item, from the supplemental report of the Board of Trustees, was received as informational.

Adopted

Reference Committee "C"

John J. Thompson, M.D., Chairman

Reference Committee "C" met at 11:00 a.m., Sunday, May 14, 1961, in the Mandarin Room, Haddon Hall. Present were Winton H. Johnson, M.D., Karl T. Franzoni, M.D., A. Guy Campo, M.D., Henry J. Konzelmann, M.D., and John J. Thompson, M.D., chairman.

The committee was complimented by the large attendance of delegates and Society members. Your committee wishes to thank the delegates, Society members, and guests for their thoughtful comments, for with these comments we were better able to consider the problems at hand. The meeting adjourned at 1:45 p.m.

1. Annual report of **Medical Service Administration** (page 371) was approved as contained in the printed material given to the House of Delegates. We wish to thank the Administration for a commendable job well done.

Adopted

2. The committee gave its unanimous approval to the **nominations** for membership on the **Board of Governors of Medical Service Administration** for 1961-62 (page 313), as submitted by the Board of Trustees of The Medical Society of New Jersey.

Adopted

3. The annual report of the **Medical-Surgical Plan of New Jersey** (page 375) was approved as contained in the printed material given to the House of Delegates. We wish to commend them for their timely and successful efforts in obtaining a premium increase to maintain the solvency of the Plan. We wish to commend them for a job well done.

The supplemental report and addendum to the annual report of Medical-Surgical Plan (page 380) were carefully weighed and the committee unanimously approved them.

Adopted

4. The supplemental report **Blue Cross Rider for Diagnostic Services** (page 318) with **Resolution #9—Joint Rider for Diagnostic Services** (page 365) from the Board of Trustees of The Medical Society of New Jersey was vigorously discussed. The supplemental report gives an accurate description of events pertaining to the joint rider since the special meeting of the House of Delegates in 1960. On the basis of the facts submitted by the Board in the supplemental report and in resolution #9, it was obvious that a great deal of study and conference with Blue Cross, Blue Shield, and the Commissioner of Banking and Insurance has taken place. With the results of these deliberations and the discussion before Reference Committee "C", it was the unanimous opinion of the members of the committee to approve the report and resolution #9. The committee respectfully **requests** the Board of Trustees to submit to the presidents of the component societies for their information the formal joint rider as drafted.

Adopted

5. The committee unanimously approved *all* the **nominations for** membership on the **Board of Trustees of Medical-Surgical Plan of New Jersey** (page 313). The committee was happy to learn that the Board of Trustees of The Medical Society of New Jersey is studying changes to be made in the method of nominations to the Board of Trustees of Medical-Surgical Plan and in the tenure of office on the Board of Trustees of Medical-Surgical Plan.

Adopted

The committee respectfully **requests** that the lising of doctor-members of the Board of Trustees of Medical-Surgical Plan include their type of practice and the component society of which they are members.

Adopted

6. The report on the **Medicare Program** (page 312) as contained in the printed material given to the House of Delegates was unanimously approved.

Adopted

7. The supplemental report of the Board of Trustees reporting Mr. Franklin H. Romaine as **Public Relations Counsel** to the **Medical-Surgical Plan of New Jersey** (page 318) was unanimously approved. Mr. Romaine was introduced to the committee.

Adopted

8. The committee gave unanimous approval to the **Resolution #10** from the Hudson County Medical Society—**Hospital Service Plan Materuity Benefits** (page 366). The committee learned of a letter from Medical-Surgical Plan to Hospital Service Plan concerning this recommendation. It learned also that the Hospital Service Plan has started study on the proposal.

Adopted

9. The committee unanimously rejected **Resolution #12—Riders for Diagnostic Services** (page 367) from Daniel B. Roth, M.D., delegate from Ber-

gen County. The committee has already gone on record, as noted above, of approving a joint rider for diagnostic services.

Amended to accept the third paragraph of the resolution:

"Resolved, that this Society express its continued opposition to all efforts by third parties, be they hospitals, insurance companies, or any others, to enter into the practice of medicine under any guise whatsoever."

Adopted as amended.

Reference Committee "D"

John B. Fuhrmann, M.D., Chairman

Reference Committee "D" met at 11:00 a.m., May 14, 1961. All members were present with the exception of Dr. Tyrrell who was absent due to illness.

The reference committee considered reports from:

1. Medical Education Committee
2. Physicians Placement Service
3. Retirement Plan for Physicians
4. Medical Defense and Insurance Committee

and submits the following as its report:

1. **Medical Education Committee** (page 333)—The reference committee agrees with the report of the Medical Education Committee and **recommends** its approval.

Adopted

2. **Physicians Placement Service** (page 354)—The reference committee compliments the Physicians Placement Service for its continued good work and **recommends** the approval of the committee report.

Adopted

3. **Retirement Plan for Physicians** (page 313)—The reference committee agrees with the decision of the Board of Trustees to await action on this matter by the American Medical Association and **recommends** the approval of this action.

Adopted

4. **Medical Defense and Insurance Committee** (page 330).

a. **Accident and Health Insurance**—It is **recommended** that the services of E. & W. Blanksteen Agency be continued as the Society's official broker for the accident and health insurance program.

Adopted

b. **Life Insurance**—It is **recommended** that the services of the E. & W. Blanksteen Agency be continued as the Society's official broker for the life insurance program.

Adopted

c. **Major Medical Insurance**—In its annual report, the committee made the following **recommendation**:

> "That the 1961 House of Delegates adopt the proposal of the National Casualty Company for major medical insurance with $500.00 deductible, and that the E. & W. Blanksteen Agency be approved as the official brokers for this program."

The reference committee is of unanimous opinion that this recommendation should be referred directly to the House of Delegates of The Medical Society of New Jersey for discussion and decision, as too many people are involved for your committee to take the responsibility for a decision. We are doing this for the following reasons:

(1) Representatives of Blue Cross have stated that if this plan is adopted they will serve notice of cancellation to all groups in New Jersey presently carrying Blue Cross if that group participates in the Major Medical Insurance Plan.

(2) Representatives of Blue Cross have also stated that on the next renewal date of any individual policy of Blue Cross they will serve notice of cancellation of said Blue Cross policy if any individual carries Major Medical Insurance with any company if there is any overlap of benefits. This includes members of The Medical Society of New Jersey who presently carry Major Medical Insurance regardless of the source of the Major Medical Insurance.

(3) Representatives of Blue Cross have also stated that on the next renewal date of Blue Cross policies there will be a statement to be signed by the individual subscriber revealing whether he carries any type of major medical coverage at this time. This will be to implement the previous paragraph.

(4) Representatives of Blue Cross have also stated that notice of cancellation of policies is being sent to members of the New Jersey State Dental Society as of Monday, May 15, 1961, because of their Major Medical Insurance coverage, unless they change their insurance plan to delete any overlap in benefits.

(5) Evidence was presented to the committee that there have been no insurance carriers found by the Medical Defense and Insurance Committee who will write a Major Medical Insurance policy that will provide for payment of catastrophic illness when Blue Cross coverage stops. All insurance carriers work on a dollar deductible basis.

(6) Paragraphs (1), (2), and (3), dealing with cancellation of Blue Cross policies, are a summation of remarks made by representatives of Blue Cross at the reference committee meeting. These remarks have been reduced to writing and are in the possession of the Chairman of the Medical Defense and Insurance Committee.

In order to get this matter formally before the House of Delegates, but without either the approval or disapproval of your reference committee, we **recommend** that action on the Major Medical Insurance plan as presented by the Committee on Medical Defense and Insurance be initiated from the floor of the House of Delegates.

Tabled (split vote 115 to 85)

Motion ADOPTED to lift item 4.c. from the table.

Motion ADOPTED that the item concerning Major Medical Insurance (item 4.c.) be referred to the Board of Trustees for study and action, and that the Board of Trustees also investigate and consider negotiations with private insurance carriers to furnish these services which we are threatened being taken away by Blue Cross.

d. **Professional Liability Insurance**—The reference committee notes with approval the progress made during the past year with our new carrier and **recommends** that the professional liability insurance program be continued through the American Mutual Liability Insurance Company.

Adopted

The reference committee further **recommends** that the component societies give their complete support to the sale of policies and implement the approved loss control program under this approved program.

Adopted

The reference committee wants at this time to thank Dr. Featherston and the members of his Committee on Medical Defense and Insurance who attended the committee meeting, for their valuable help in arriving at our decisions.

Reference Committee "E"

John W. Holland, M.D., Chairman

Reference Committee "E" met on Sunday, May 14, at 11:00 a.m., with all members present: Drs. George L. Nicoll, Sherman Garrison, Jr., C. Spencer Davison, George E. Barbour, and John W. Holland, chairman.

Health Officer Qualifications (page 313)—This report was discussed at length before the committee by the Society's Legislative Analyst (E. Powers Mincher). The committee voted to approve this report. Adoption by this House of the recommended approval made by the reference committee will necessitate immediate action by the House to rescind its action of 1960 adopting the original resolution (#10).

Adopted

Action of 1960 House adopting original resolution (#10) rescinded

Council on Legislation (page 340)—The committee unanimously approved the report, together with supplemental reports on state and national legislation. In view of discussion on the supplemental report on state legislation, this committee **recommends** that each member of this House express to his state senator the opposition of The Medical Society of New Jersey to A-197 and A-128. The committee wishes to commend Dr. Blaisdell and his Council on Legislation for the excellent work in this field, and expresses appreciation to Dr. Blaisdell personally for his long and faithful service.

There was discussion on the legislation to amend the **school examination law (S-66)**. The reference committee urges each member of the House to bring to the attention of his local board of education the fact that this is permissive, not mandatory, legislation.

Adopted

Policy Decision—Introduction of Legislation (page 315)—This report was unanimously approved.

Adopted

Council on Public Relations (page 344)—This report was unanimously approved. The committee commends the council for the scope and efficiency of its work.

Adopted

Future Physicians Clubs—Resolution #4 (page 362)—The committee unanimously approved this resolution—introduced by the Essex County Medical Society—but with deletion of the final "resolved" as superfluous.

Adopted

Social Security for Physicians—Resolutions #5, #6, #13 (pages 362, 363, 367)—The committee considered these three resolutions on Social Security—presented by Mercer, Passaic, and Sussex County Medical Societies. Since the intent of all the resolutions is to instruct our delegates to the American Medical Association to vote favorably for inclusion of physicians under Social Security, the reference committee offers the following substitute resolution as embodying the intent of all three:

Whereas, the members of the House of Delegates of the American Medical Association have continued to oppose the compulsory inclusion of physicians under Social Security; and

Whereas, the Congress of the United States has not as yet enacted a law to effect such inclusion; and

Whereas, this House of Delegates in 1959 approved inclusion of physicians of New Jersey under Social Security; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey recommend to its A.M.A. delegates that a resolution be introduced at the next meeting of the American Medical Association recommending the extension of Social Security to include physicians; and be it further

Resolved, that the delegates of The Medical Society of New Jersey to the American Medical Association be clearly mandated to support this resolution, or any other favoring the inclusion of physicians under the Social Security program.

Adopted

Medical Corporations or Associations—Resolution #15 (page 368)—This resolution—presented by the Mercer County Medical Society was approved.

Adopted

Reference Committee "F"

Nicholas E. Marchione, M.D., Chairman

The committee met at 11:00 a.m., on May 14, 1961, in the Rowsley Room at Haddon Hall, with all members present—Drs. Herschel S. Murphy, Thomas C. DeCecio, Harry R. Brindle, Blackwell Sawyer, and Nicholas E. Marchione—and many fellow-delegates and members of the Society.

1. The first item to be considered was the annual report of the **Special Committee on Industrial Health** (page 345). We commend the committee for its conclusions and **recommend** the adoption of this report.

Adopted

2. The report of the **Special Committee on Workmen's Compensation** (page 346) was read. Dr. Lepree was present and further elaborated on this report. We thank Dr. Lepree and his committee for the excellent work they are doing and **recommend** the adoption of this report.

Adopted

3. The item from the annual report of the Board of Trustees referring to **Medical-Legal Testimony** (page 315) was read and discussed. We thank the Board of Trustees for this report and endorse its action. We **recommend** its acceptance.

Adopted

4. **Resolution #16—Assistant Secretary of Defense (Health and Medical)** (page 369) was read and various members of Bergen County discussed it. We thank Bergen County for its recognition of the responsibilities of the medical profession to further the best of medical care in all areas, be they civilian or otherwise. We **recommend** adoption of this resolution.

Adopted

5. The report of the **Council on Medical Services** (page 342) was read. The portion dealing with medical care to the indigent on a vendor payment system, being purely informative, was accepted.

The reports of the Special Committees on Workmen's Compensation and Industrial Health, hav-

ing been previously considered and accepted, no further action was deemed necessary.

Adopted

In the matter of the report on the **Proposed Relative Value Index for New Jersey** (page 342), considerable discussion ensued and both sides of the question were ably presented. Dr. Klompus and his council are to be commended for the many hours of work that have gone into the study of this question. The committee finds that the Relative Value Index has merit in establishing a relationship between various services as rendered by physicians but our hearings today convince us that thought is not sufficiently crystallized in our various counties to recommend definite action at this time. Therefore, we **recommend** further study for another year by all the parties concerned and that this matter be presented again at the next meeting of the House of Delegates, annual or special.

Adopted

6. The item in the annual report of the Board of Trustees regarding the **Proposed Relative Value Index for New Jersey** (page 316) was read and being purely informative, it was accepted.

Adopted

7. Since the committee had agreed to defer action on the matter of the Proposed Relative Value Index, no action is **recommended on** Resolution **#7 from Camden County** (page 364).

Adopted

I wish to thank all the discussants for their participation and presentation of their views at this reference committee. I further wish to thank the members of my committee for their valuable help, guidance and comments on the formulation of this report. I especially wish to thank Dr. DeCecio, who acted as secretary for the committee.

Reference Committee "G"

Lester R. Wilson, M.D., Chairman

Reference Committee "G" met at 11:00 a.m., on May 14, 1961, with all members present—Drs. Spillane, Stineman, Gullord, Boylan, and Wilson. Many delegates attended and discussions were permitted.

1. The report submitted by the **Council on Public Health** (page 343) was approved.

Adopted

2. The report of the **Special Committee on Cancer Control** (page 346) was approved as submitted.

Adopted

3. The report of the **Special Committee on Child Health** (page 347) was approved as submitted.

Adopted

4. The report of the **Special Committee on the Chronically Ill and the Aging** (page 348) was approved as submitted.

Adopted

5. The report of the **Special Committee on Conservation of Hearing and Speech** (page 349) was approved with deletion of the following paragraph:

> "It is suggested that all hearing aid fitters and dealers be certified and licensed by the State. In order to qualify for certification these dealers should pass a written and performance examination to insure a minimum degree of competence and knowledge in a number of areas as they relate to the fitting of hearing aids. The law also should forbid unethical advertising or high pressure selling technics."

Deletion of this last paragraph of the report is **recommended** because it is not in the best interest of medical care, nor is it in the best interest of the public itself.

Adopted

6. The report of the **Special Committee on Conservation of Vision** (page 350) was approved as submitted.

Adopted

7. The report of the **Special Committee on Maternal and Infant Welfare** (page 351) was approved as submitted.

Adopted

8. The report of the **Special Committee on Mental Health** (page 352) was approved as submitted.

Adopted

9. The report of the **Special Committee on Rehabilitation** (page 353), with the exception of recommendation #1, was approved. Recommendation #1 was disapproved in accordance with the comment and reasons given by the Board of Trustees.

Adopted

10. The item from the annual report of the Board of Trustees on **Pilot Plan for Eye Care on a Funded Basis** (page 317) was considered as information and was accepted, in view of the approval of the recommendation of the Special Committee on Conservation of Vision that the plan be disapproved.

Adopted

11. **Resolution #8—Influenza Immunization Campaign** (page 364), submitted by the Passaic County Medical Society, was approved as submitted.

Adopted

12. **Resolutions #11 and #14—Relation of Medicine to Optometry** (pages 366, 368), were considered as one, as they are of the same intent. We approve the content of Resolution #11, but request adoption of Resolution #14 as it is in more detail. This procedure was accepted by the Mercer County delegation.

Adopted

Reference Committee "H"

Donald T. Akey, M.D., Chairman

Reference Committee "H" met on Sunday, May 14, at 11:10 a.m., with the following members present: Drs. Nicholas Demy, Frederick Dilger, Nathan Plavin, and Donald T. Akey, chairman. Absent was Dr. Morris H. Saffron.

Honorary Membership (page 329)—The chairman brought to the attention of the members that the report on Honorary Membership Committee had been tabled by majority vote at the first meeting of the House of Delegates on May 13, 1961.

No action

Annual Meeting Committee (page 326), **Subcommittee on Scientific Exhibits** (page 327), **Subcommittee on Scientific Program** (page 327), **Woman's Auxiliary Advisory Committee** (page 339)—All these reports were accepted by unanimous vote.

Adopted

Emeritus Membership (page 356)—This report, together with supplemental nominations, was accepted by unanimous vote.

Adopted

Special Committee on Traffic Safety (page 355)—This report was accepted by unanimous vote.

Adopted

It is noted with regret and sorrow that Dr. Lewis C. Fritts and Dr. Aldrich C. Crowe, who prepared two of our reports, have since died.

Reference Committee on Constitution and Bylaws

Andrew C. Ruoff, III, M.D., Chairman

The Reference Committee on Constitution and Bylaws met at 11:00 a.m., Sunday, May 14, 1961, with all members of the committee present—Dr. Ruoff, chairman; Dr. Eynon, Dr. Stamps, Dr. Smith, and Dr. Zimmerman.

The following items were considered:

1. **Amendments** to the Constitution and Bylaws **from the Union County Medical Society** co-sponsored by the Cumberland, Middlesex, and Ocean County Medical Societies (page 357).

After discussion with all interested parties, the committee was of the opinion that enlarging the Board of Trustees could result in an unwieldy body which could dilute its effectiveness. However, the committee was of the opinion that the House of Delegates should once more have the opportunity to vote on the proposition as to whether the manner of election of the Board of Trustees should be changed to one in which the component societies will elect their representatives. In order that the House of Delegates may decide on this proposition the reference committee **recommends** that the Constitution, Article VI—Board of Trustees, be amended, with the further **recommendation** that the method of proration be one (1) elected Trustee from each component society on the basis of one thousand (1,000) members, or major fraction thereof—(for a total of twenty-one or possibly twenty-two):

CONSTITUTION

ARTICLE VI — BOARD OF TRUSTEES

Current

The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall be elected for a term of three (3) years, such term to commence upon expiration of the then incumbent.

Reference Committee Recommendations

Section 1—Composition

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Each component society shall be entitled to one (1) elected Trustee.

The larger component societies shall be entitled to one (1) elected Trustee for each thousand (1000) members or major fraction thereof as of December 31 of each year. Trustees shall be elected from and by component societies prior to the proper annual meeting of the House of Delegates. The term of office shall be three (3) years and such term shall commence upon the expiration of the term of the incumbent. The tenure of office of approximately one-third (1/3) of the elected Trustees shall terminate annually.

Section 2—Procedure

Following the adoption of these amendments incumbent Trustees shall serve out their elected terms as representatives of the component societies in which they hold membership. Remaining and succeeding Trustees shall be elected by component societies the year following the adoption

of these amendments for one (1), two (2), or three (3) year terms—to equalize the process.

Section 4—Filling Vacancies

In the event that the office of any elected Trustee becomes vacant the component society wherein the vacancy occurs shall elect a successor within ninety (90) days, to fill the unexpired term.

Defeated (Split vote, 127 to 220)

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2. **The proposed changes in the Bylaws** (page 359), to accomplish the change in the manner of election of the Board of Trustees will more advantageously be discussed and acted on at the 1962 annual meeting of the House of Delegates since the proposed Constitutional amendment, if passed, will still have to be presented then for final action, and the Bylaws amendments which only require one reading could be accomplished at the same time. Passing them this year would be of no value.

Not adopted

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3. **Article IV—Organization of the Society; Section 4—Delegates** (page 338). It is recommended that this section be amended to read:

Current

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Proposed

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each twenty (20) members, unless otherwise stipulated by the House of Delegates in the interest of maintaining the total membership of the House so that it does not exceed four hundred (400) members, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Amended to read:

Each component society shall be entitled to one (1) delegate for each twenty (20) members or major fraction thereof, . . .

Approved as amended for final consideration in 1962.

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4. Proposed **amendment** to the Constitution, **Article VI—Board of Trustees** (page 357), is presented to the House of Delegates for final vote, which requires two-thirds (⅔) majority for adoption. It is proposed, as approved last year, that any member may be elected a Trustee for a maximum of three (3) full terms.

Current (second paragraph)	**Proposed**
From and after May 21, 1953, any member may be elected a Trustee for a maximum of three (3) full terms, provided, however, that if the first two (2) elected terms are successive, there shall be a lapse of one (1) year between the expiration of the second and commencement of the third term. The term of any Trustee commencing prior to May 21, 1953, shall not be included in the limitation of three (3) elected terms.	Any member may be elected a Trustee for a maximum of three (3) full terms.

Adopted

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5. The reference committee accepted the report of the **Committee on Revision of Constitution and Bylaws** (page 336), and unanimously commended Dr. Albright and his committe for the excellent work done.

Adopted

REPORT OF THE NOMINATING COMMITTEE AND ELECTION

(May 14, 1961)

Office	*Term*	*From*	*To*	*Nominee*
President-Elect	1 year	May 1961	May 1962	Louis S. Wegryn, Union County
First Vice-President	1 year	May 1961	May 1962	Carl N. Ware, Cumberland County
Second Vice-President	1 year	May 1961	May 1962	Charles H. Calvin, Middlesex County
Secretary	1 year	May 1961	May 1962	Marcus H. Greifinger, Essex County
Treasurer	1 year	May 1961	May 1962	Daniel F. Featherston, Monmouth County
Trustees:				
1st District	3 years	May 1961	May 1964	Jerome G. Kaufman, Essex County
4th District	3 years	May 1961	May 1964	Louis F. Albright, Monmouth County
5th District	3 years	May 1961	May 1964	Louis K. Collins, Gloucester County
Judicial Councilor:				
3rd District	3 years	May 1961	May 1964	Gerard R. Gessner,* Middlesex County
*—Dr. Gessner declined the nomination. Nomination from the floor:				Albert F. Moriconi, Mercer County
AMA Delegates:				
(unexpired term of Aldrich C. Crowe, deceased)	6 months	June 1961	Dec. 1961	Isaac N. Patterson, Gloucester County
	2 years	Jan. 1962	Dec. 1963	Isaac N. Patterson, Gloucester County
	2 years	Jan. 1962	Dec. 1963	William F. Costello, Morris County

A.M.A. Alternates:				
	18 months	June 1961	Dec. 1962	Frank J. Hughes, Camden County
(unexpired term of Robert N. Bowen, non-member)				
	2 years	Jan. 1962	Dec. 1963	Elton W. Lance, Union County
	2 years	Jan. 1962	Dec. 1963	John L. Olpp, Bergen County
Delegates and Alternates to Other States:				
New York:				
Delegate	1 year	For 1962 Convention		William F. Costello, Morris County
Alternate	1 year	For 1962 Convention		Levi M. Walker, Atlantic County
Connecticut:				
Delegate	1 year	For 1962 Convention		Lloyd A. Hamilton, Hunterdon County
Alternate	1 year	For 1962 Convention		S. Eugene Dalton, Atlantic County
Administrative Councils:				
Legislation				
3rd District	3 years	May 1961	May 1964	Leonard Rosenfeld, Hunterdon County
6th Member	3 years	May 1961	May 1964	Nathan J. Plavin, Hudson County
Medical Services				
3rd District	3 years	May 1961	May 1964	Durant K. Charleroy, Mercer County
6th Member	3 years	May 1961	May 1964	Donald B. Hull, Bergen County
Public Health				
3rd District	3 years	May 1961	May 1964	Elmer J. Elias, Mercer County
5th District	2 years	May 1961	May 1963	Harvey N. Vandegrift, Atlantic County
(unexpired term of Gene N. Schraeder, resigned)				
6th members	3 years	May 1961	May 1964	Samuel C. Yachnin, Passaic County
Public Relations				
3rd District	3 years	May 1961	May 1964	George E. Barbour, Somerset County
6th Member	3 years	May 1961	May 1964	Norman K. Boudwin, Burlington County
Standing Committees:				
Annual Meeting	3 years	May 1961	May 1964	Peter H. Marvel, Atlantic County
Finance and Budget	3 years	May 1961	May 1964	Wayne H. Stewart, Cape May County
Medical Defense and Insurance				
	3 years	May 1961	May 1964	Daniel F. Featherston, Monmouth County
Medical Education	3 years	May 1961	May 1964	Malcolm M. Dunham, Middlesex County
Publication	2 years	May 1961	May 1963	Frank L. Rosen, Essex County
(unexpired term of Joseph F. Mott, deceased)				
	3 years	May 1961	May 1964	C. Spencer Davison, Salem County
Woman's Auxiliary Advisory				
	3 years	May 1961	May 1964	A. Guy Campo, Gloucester County

Upon motions duly made, seconded, and carried, all nominees were elected to the designated offices and for the terms indicated.

MEMORIAL

to

George N. J. Sommer, M.D., E. Zeh Hawkes, M.D., Aldrich C. Crowe, M.D., and Lewis C. Fritts, M.D.

The following resolution from the Board of Trustees was read by President McCall and unanimously **adopted** at the first session of the House of Delegates on Saturday afternoon, May 13, 1961:

Whereas, God, in His omniscience, in the course of the administrative year now ending, has seen fit to summon through death George N. J. Sommer, M.D., E. Zeh Hawkes, M.D., Aldrich C. Crowe, M.D., and Lewis C. Fritts, M.D.—all Fellows of The Medical Society of New Jersey; and

Whereas, by their lives and actions as members of the medical profession, they have reflected great credit upon their colleagues and their profession, and have rendered exemplary service to their fellowmen; and

Whereas, by their constructive endeavors they have distinguished themselves as members and former Presidents of The Medical Society of New Jersey; therefore be it

Resolved, that The Medical Society of New Jersey, by action of this House of Delegates, acknowledge that as it was enriched by their living it is impoverished by their dying; and be it further

Resolved, that The Medical Society of New Jersey record its grief at their passing, and pledge to them an enduring and honored place in its official records and in the hearts of its members; and be it further

Resolved, that a copy of this resolution, suitably indited, be furnished to the bereaved families of these dear departed, with deep respect and sympathy.

1960 TRANSACTIONS

At its first session on Saturday afternoon, May 13, 1961, the House of Delegates **approved:**

The Transaction of the 1960 House of Delegates as published in the July, 1960 JOURNAL and distributed to the membership.

President's Address*

Jesse McCall, M.D., Newton

Some two years ago I sat on the beautiful lawn of the University of Virginia, listening to Dr. Colgate Darden address several hundred graduates of the University. Many of the things he said about Thomas Jefferson and his influence on educational systems—public and private—were accurate and illuminating, I am sure, but for some perverse reason I have retained in sharp memory a few words that he said at the end of his address. Retiring as President of the University, Dr. Darden said, "I shall take my leave of you not with any word of advice. I have lived long enough to know that I have not the wisdom to advise others, nor have I the slightest wish to do so."

In my position, I can subscribe wholeheartedly to the thought that I do not have the wisdom to advise others, but I do feel that I should take this opportunity of alerting you to certain weaknesses in our Medical Society structure which I have observed during the year. That year of activity has been described rather completely in my annual report. It has been extremely active, reasonably productive and rewarding—certainly from my own viewpoint and, I hope, from the standpoint of the Society.

The weaknesses are possibly great in number, but I will focus attention only on one or two:

First, "failure of communication" . . . Early in the past administrative year, we attempted to augment our regular, established lines of communications with component societies by a conference of presidents. Through the year a stream of correspondence flows from Trenton to the county societies. The *Membership News Letter* regularly, in capsule form and under an able editor, provides the members of our Society with an up-to-date evaluation of problems related both to the calendar and to policy. And yet an astonishing percentage of our membership does not seem to know what is going on.

Examples to prove my point—and I know there are many more—I picked these, in a sense, off the top of my head: the matter of insurance coverage has undergone close scrutiny and the development of a change of policy during the past year. Within, I would say, the last couple of months an elder statesman in my own county area approached me as to the reasons for making any change from his old insurance coverage—professional liability-wise—to a new insurer. His argument was very simple and possibly an expected one, if he had not followed any of the lines of communications that we have been trying to maintain from the state society and our very appropriate Committee on Medical Defense and Insurance to the individual member. His question was this: "I have always been treated very fairly by my present carrier. Why should I throw him over?" Well, of course, it took only two minutes and I didn't even have to develop this because I had knowledge of the individual. The fine care that he had had by his current insurance carrier and the one that he had depended upon for several years depended on simply the regular submission of his premium and the return of a receipt for the check. He had never had a claim of any type, nor had there been any disagreeable feature associated with his insurance, so naturally he would know of no particular reason for a change based on his own limited and somewhat provincial attitude toward the whole matter.

Another example along the same line, and this relates to the Medicare contract, a matter of public law—or at least it has been the implementation of public law passed back in 1958. This, by the way, is no particular brief for Medicare as a medical principle or modality at all. I'm merely using this as an instrument to prove the point I'm talking about.

The President during the year receives a lot of letters. Some actually would prove of real interest in various fields, that of pure humor, pathos and all other human emotions. Some tend to make, I guess, one rather discouraged with one's job and impatient with the fact that one is trying so hard to do a job for the Society and yet finds so many people who do not know the little intimate details of procedure that they should know.

This incident involved a chap who should be at least in the know. He is a past-president of a component county society, not my own, in this situation. He has had experience in the halls of this particular hotel and other places where medical society councils and bodies have met. He apparently had a Medicare case, the

*House of Delegates, May 15, 1961.

first and only one he's ever had in his experience. After his treatment, the nature of which is not important, he then submitted a bill on his own stationery, sent to an address which he supposed was the proper one or possibly he had been advised as to where it should go. When the bill was returned, he took one glance at it and apparently turned violently red, decided that some radical decision should be made by the Medical Society.

Here he had submitted a bill on his own stationery to a facility that has its own billheads, it has its own fee schedule which we may not like, but still it has by public law a fee schedule, and then he had wondered why it had not been processed promptly. So because it had not been processed he though that something should be done about it.

The bill itself had a series of charges that used the figure 8, $8 for something. I was on the original committee that negotiated the contract, a job assigned to me, by the way, not necessarily one of choice, that negotiated the contract coverage, the Medicare law for The Medical Society of New Jersey. I, myself, I think, have had approximately three Medicare contracts or Medicare cases in the years since 1958. I, however, have had service on disputed bills in regard to Medicare contracts and I have gone over, many times, the schedule of benefits, and in that entire schedule I believe the figure 8 is never used except in the code designations that describe a particular type of service. And yet because his bill had been returned, this physician declaimed in a long last fiery paragraph to me: "I think as President of The Medical Society of New Jersey you should see that the Medical Society dissolves its association, its contract with the United States Government." That is evidence, I think—it's an extreme example, I grant you, but this extreme comes in a man who belongs in our younger group and who should know.

A third example involves a very personal matter. When I was busying myself during these last two or three weeks trying to get my head clear and my thoughts along the right line in order to be able to take care of this meeting and all the various plans involved, here comes a notice over my desk! The regular annual dinner meeting of such and such a county society is to be held at 6 o'clock or 8 o'clock on the evening of May 16. May 16, I believe, is tomorrow. You would like to know, I'm sure, what county society this was. It was Sussex, my own. (Laughter). It's true, of course, that this particular date originally was set by a fairly honest error, I would suppose. It was changed, I assure you, and I did attend the meeting.

Next, there seems to be an abysmal lack of knowledge as to the significance of the job of organized medicine. I have traveled widely through the state during the year. For every one doctor who seems to feel and express his awareness of the significance of the job of organized medicine, I meet twenty who ask. "How do you find the time?"

Gentlemen, the time is here and now. And the time is not always your own, as it hasn't been mine. But we cannot profess to be dedicated, alert, intelligent individuals pursuing the ideals and trying to elevate those ideals of our profession unless there is a sacrifice of time in some direction. What I worry about most is that the proper individuals who have the most to contribute and the most facile ways of making the contribution are those who make the sacrifice. The only way that those can be chosen of course, is by adequate discernment on the part of every member of the society in their county meeting and your meetings here in this particular hotel and in this city for our annual gathering.

The time is not one to retire into an ivory tower of scientific absorption, with all due credit to my dear friend, Jerry Kaufman, and his scientific program which I understand, by the way, is probably one of the best that we have ever had—in recent memory anyway. Nor is it a time for any frenetic burst into the materialistic side of medical practice. The time is here and now to combine the efforts of the individual and the organization of medicine as a whole; to preserve the position of the doctor as a scientist, yes—but more importantly—as an artist, in the area of public respect and confidence.

Our failure to meet in conference with other institutions and agencies of our existing socioeconomic world has been described as a weakness. Our patients want a ruggedly individualistic doctor, but the world—at least the press—wants our minds, our motives open for public inspection—a guided tour. I assure you that throughout the year, your President, Executive Committee, Board of Trustees, and Councils have been diligent in meeting these demands. If, after sitting in conference with various agencies, we have failed to agree, you may rest assured that failure has been due to our unwillingness to compromise the basic integrity of The Medical Society of New Jersey, exemplified through almost two centuries of service to the citizens of this state.

Through you, gentlemen, the members of the House of Delegates, I should like to thank

The Medical Society of New Jersey for its confidence and support in a year of active service marked by a feeling of great personal reward.

The full and seemingly tireless devotion of the Executive Officer, the Administrative Secretary, and the entire staff in the Trenton Office has been mine from the beginning. I am sure that many of their days have been modified by drudgery and routine, and yet they have by skillful performance removed these days from my ken and developed a complete, cooperative effort in which I have been able to play a prideful part.

Introduction of Dr. Buchanan to House of Delegates*

G. Homer Bloom, M.D.: President McCall, Officers of The Medical Society of New Jersey, Delegates, Fellow Members of The Medical Society of New Jersey, Ladies and Gentlemen of the audience:

I am not sure whether I will be blamed or be given a small share of credit for the man about whom I am supposed to make a few remarks this morning. I hope it will be the latter.

When he asked me to introduce him to this body I accepted with pride as I hope that perhaps I have contributed in some small way in the events of his professional life leading up to this happy occasion.

I first met Ralph in September 1934, when I interviewed him for a residency in the Warren Hospital of Phillipsburg, where I was and still am the Chief of the Department of Surgery.

Instead of leaving the Warren Hospital after three months to accept a residency in New York City as he had planned, he remained with us for two years. He then opened his office in Phillipsburg. We have been closely associated since that time.

He was born November 23, 1907 in the small town of St. Clair, in the hard coal mines area of Schuylkill County, Pennsylvania. He is the seventh son of John and Mary Buchanan, all boys, no girls. His pre-high school days were in the same school district, his high school training in Pottsville, Pa. His track abilities won him a scholarship to Mercersburg Academy where he spent one year. Lafayette College in Easton, was the scene and location of his pre-medical training. Incidentally, he always said he was going to become a doctor.

Perhaps you people wonder why the name . . . Ralph M. L. Buchanan! Their family physician was Ralph McKay Lashelle. I wonder if this has any bearing on his selection of medicine as his chosen profession?

From Lafayette he went to Hahnemann Medical College in Philadelphia, from where he graduated in 1933. During his senior year, to help defray expenses, he accepted a junior internship in the County Hospital at West Chester, Pa. He commuted daily. His rotating internship was taken at Abington Memorial Hospital, Abington, Pa. Then he came to dear old Phillipsburg.

He has been a member of The Medical Society of New Jersey since 1935. He was elected President of the Warren County Medical Society in 1939 and served two successive terms, an honor never before and never since given anyone in the County of Warren. He enlisted in the Medical Corps of the United States Naval Reserve and served his country in the Pacific Theatre until being discharged in January 1946.

On return from World War II he re-activated his interests in the Warren County Medical Society and has served as its Secretary the past 12 years. He has been a delegate to this annual convention except for the time spent in the Navy. He has served as a member of your Publication Committee from 1948 until 1956; at your May 1956 meeting you elected him Councilor for the First District. He has also served you as Chairman of the Committee on Rural Health. In April 1957, you saw fit to start him on his present road by selecting him as your choice as Second Vice-President.

No one is more aware of the great amount of time and effort he has given to the Society than I am. I frequently wished he would spend more time in Phillipsburg caring for his busy practice rather than attending the many neces-

*House of Delegates, May 15, 1961.

sary meetings relating to the State Society, as I was the one who usually covered for him. We cannot hope for any change in that respect during the coming year.

Dr. Buchanan is interested in industrial medicine. He has been Medical Director for Ingersoll-Rand Company since May 1946. He served as Treasurer of the Industrial Medical Society of New Jersey prior to being elected as the President of the same organization in 1959-60. He is a Fellow of the Industrial Medical Association since April 25, 1956.

Dr. Buchanan is a Fellow of the American College of Surgeons; a Fellow of the International College of Surgeons; a member of the Society of Surgeons of New Jersey where at present he serves on its Executive Committee. He was appointed to the State Board of Medical Examiners of New Jersey in August 1954. He is serving his fifth term as the President of said Board, an accomplishment only our own David B. Allman can equal. No one ever before has served any longer than two successive years.

Again I can be given credit, or blamed, for bringing together one Grace Sharp Albinson of Easton, Pa. and one Ralph M. L. Buchanan. The first named was referred to me as a surgical patient. Shortly thereafter I went on vacation and left her in what I thought at the time as in his hands, so to speak. I was wrong—it must have been in his heart or their hearts! They were married and have four children, whom those of you who were at the reception last night had the pleasure of meeting. Dr. Buchanan is the third President from Warren County—the first in 83 years. The first one was Dr. John C. Johnson, from Blairstown, your 74th President in 1867; and in 1878 Dr. John S. Cook from Hackettstown, as your 85th President. I think Dr. Buchanan's number will be the 169th.

According to the Alumni Association office of the Hahnemann Medical College, he is the first graduate of their institution ever to be chosen for the Presidency in any of our 50 State Societies.

We, of the Warren County Medical Society, the Warren Hospital, the people of our community, and I, personally, take great pleasure in giving you your newly elected President—Ralph M. L. Buchanan.

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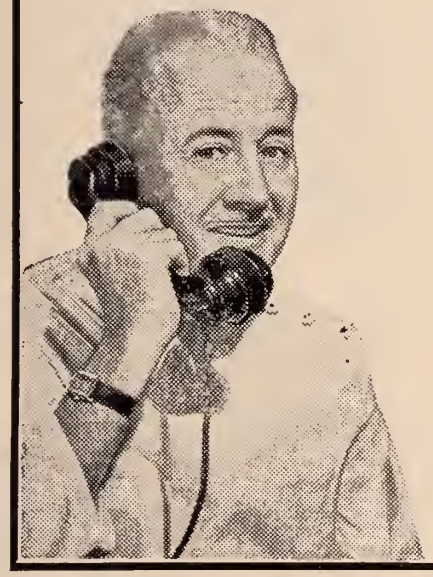
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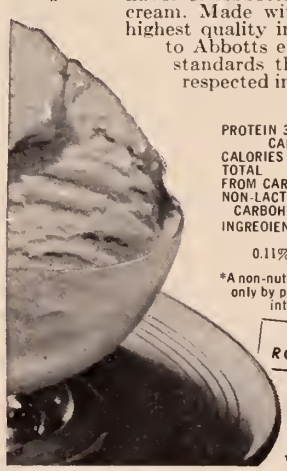
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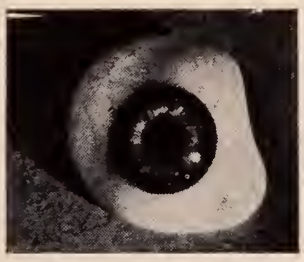
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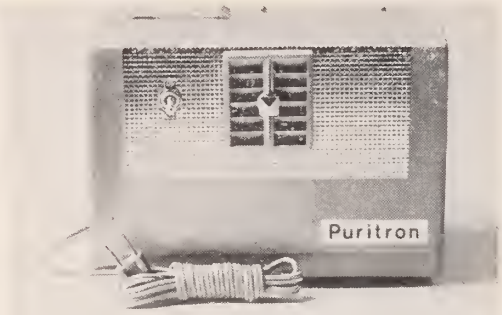
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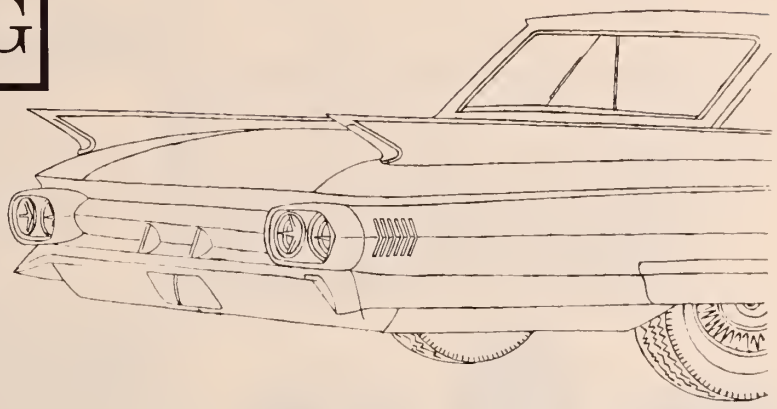
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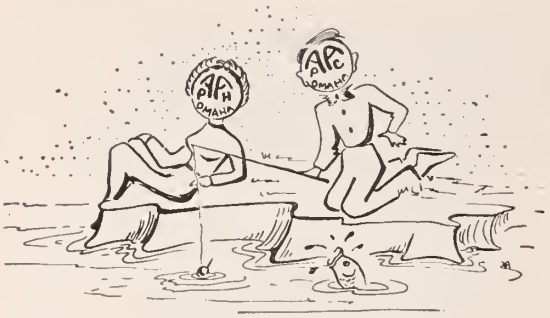
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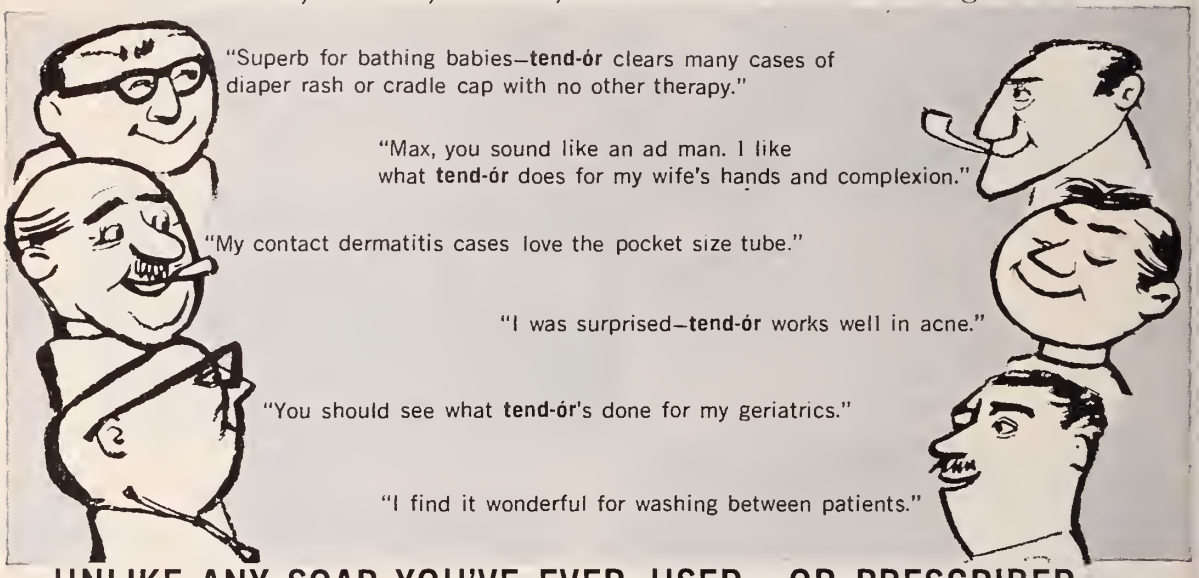
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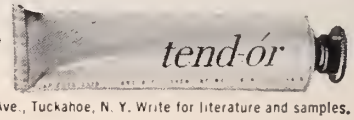
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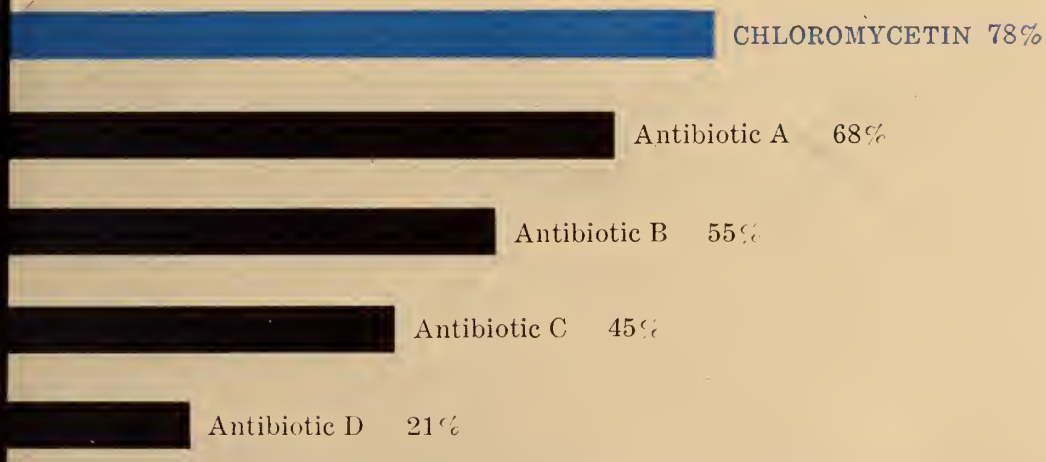
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THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 58, No. 8 AUGUST, 1961 Subscriptions, $3.00 per Year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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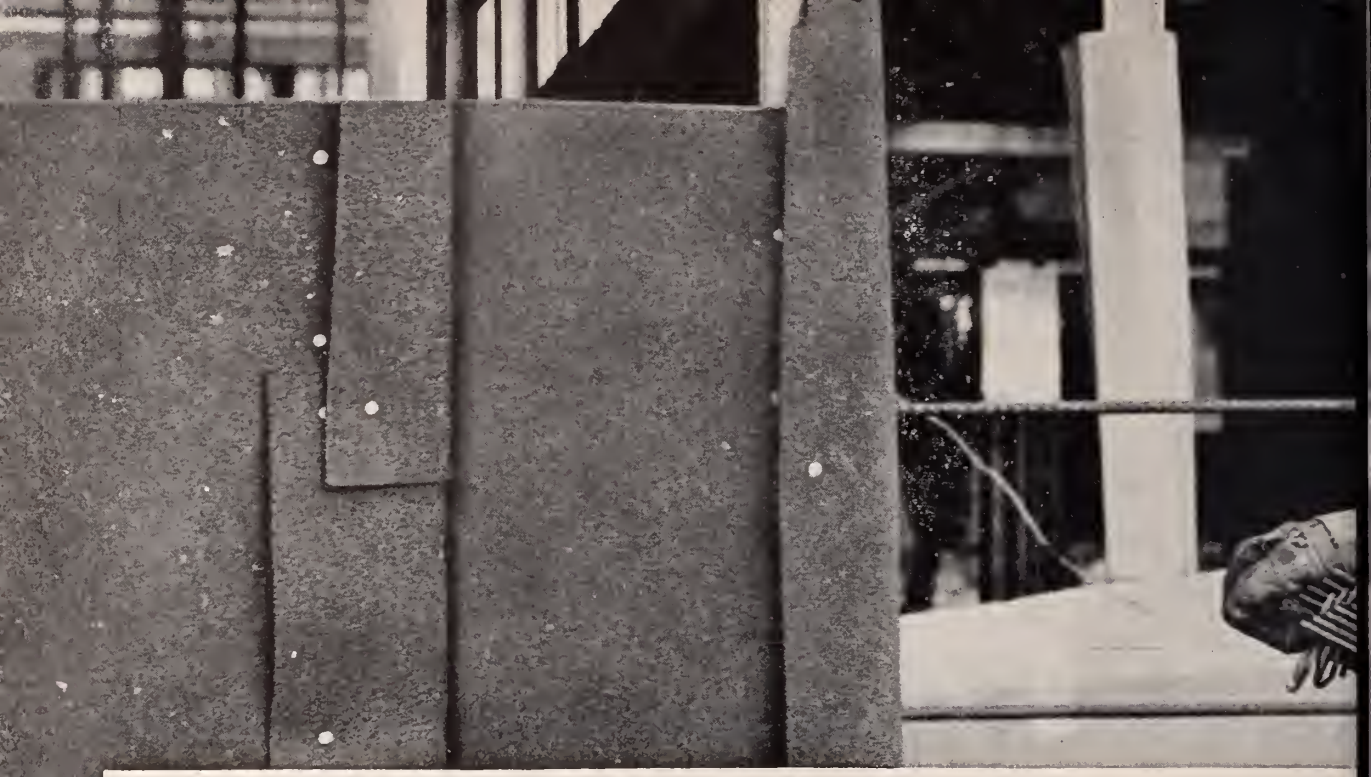
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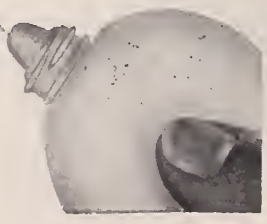
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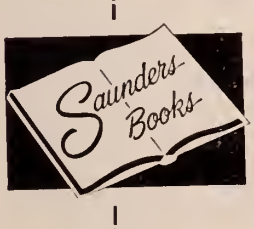
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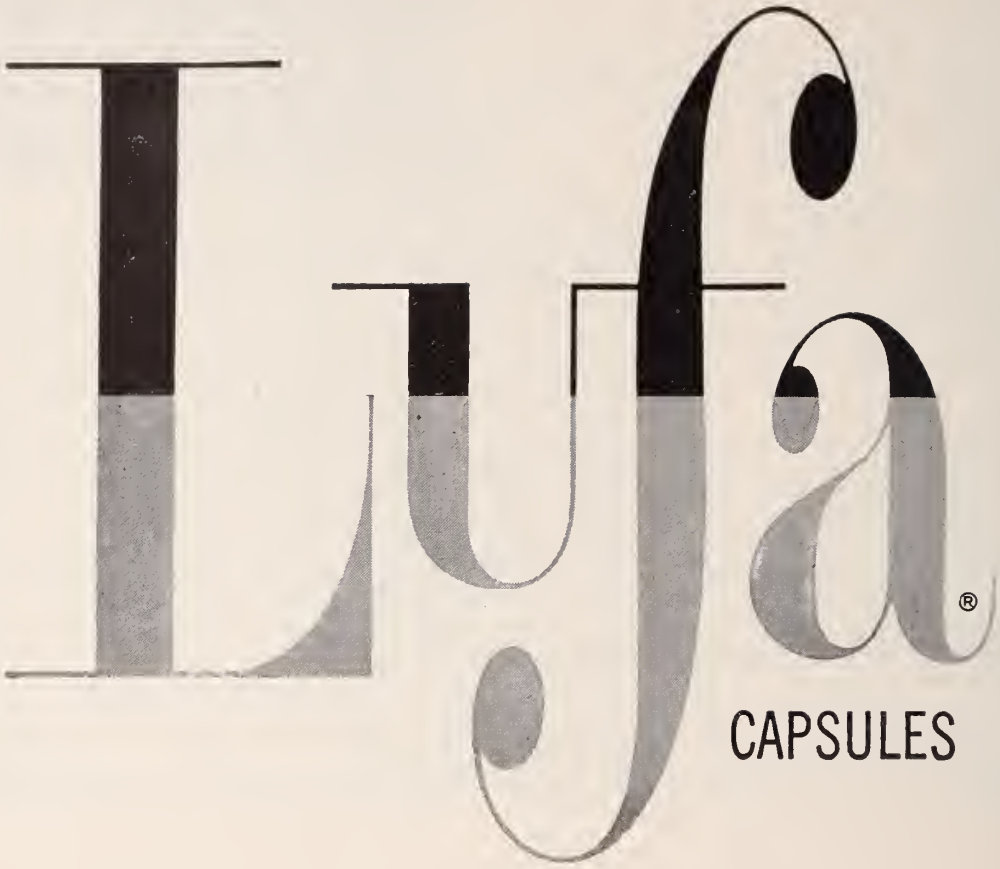
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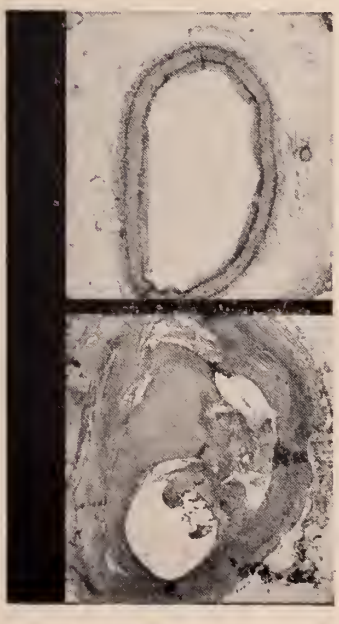
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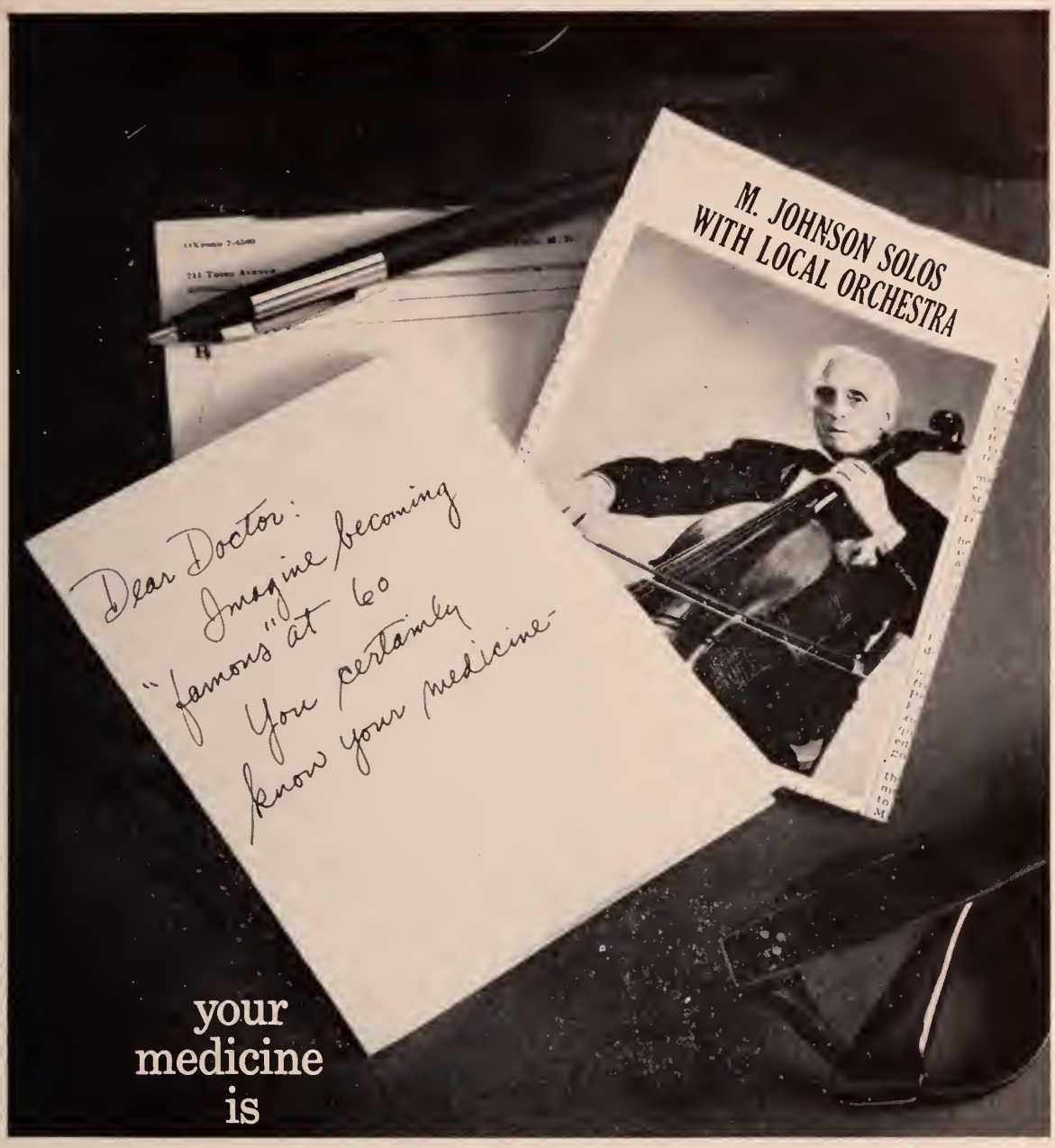
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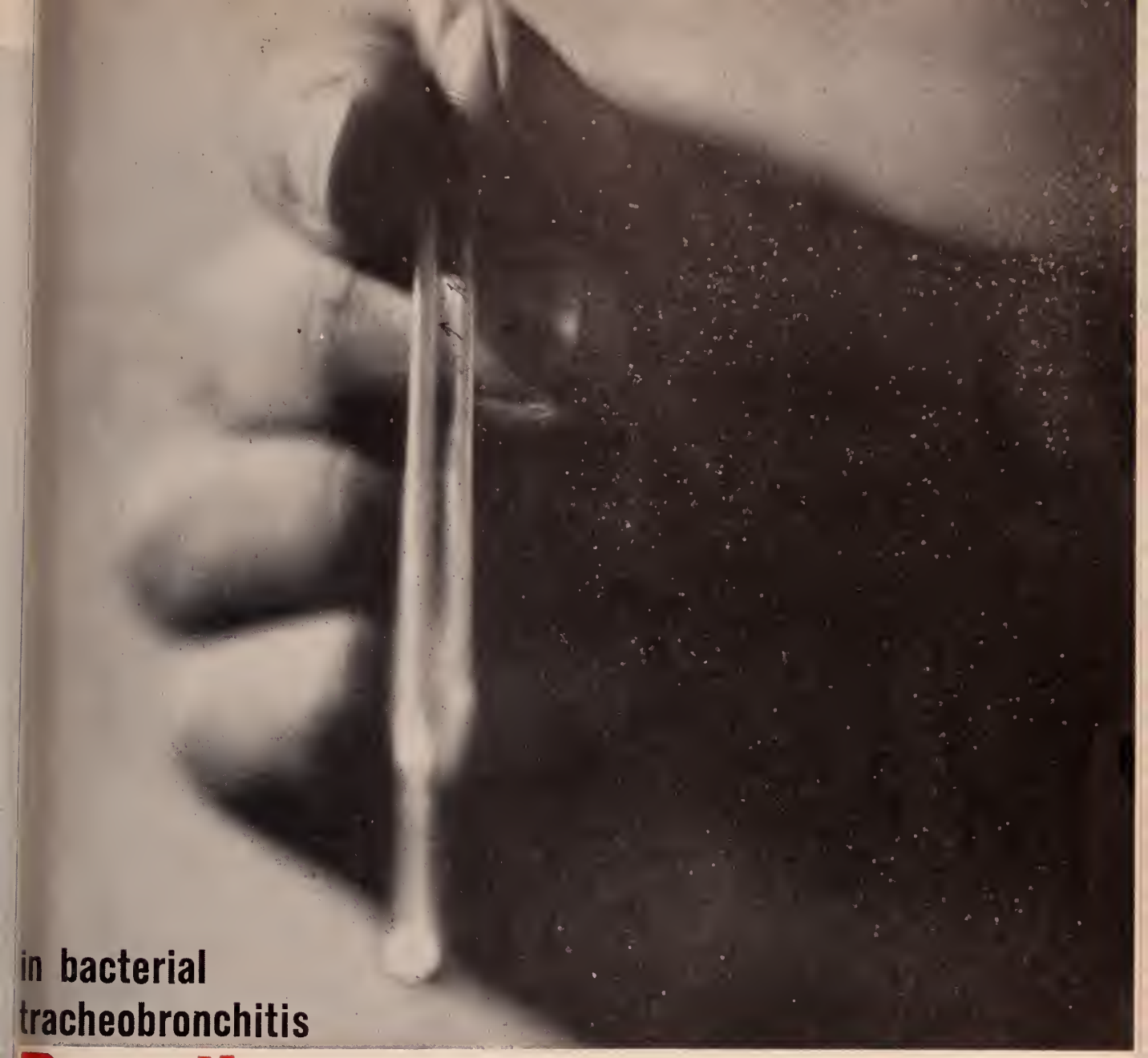
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A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.
Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, a few cases of leukopenia and agranulocytosis have been reported in patients treated with Albamycin. Most of these side effects usually disappear upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken.
Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

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One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

"The naive belief that, if a product was not good, the FDA would prohibit its sale is just not realistic. . . . it is completely impossible for the FDA to check every batch of every product of every manufacturer. . . . Hence the integrity and reputation of the manufacturer assume unusual significance where drugs and health products are concerned."

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doleseents—who require nutritional support because of growth needs and poor dietary selection.[3]

regnant patients—who often require sound, easily olerated, and convenient nutritional supplementation during pregnancy and lactation.[4]

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offers a scientifically balanced ratio of carbohydrate, protein, and fat. Each 12½ fl. oz. can of Nutrament liquid provides 400 calories. Caloric distribution: protein–20% (20 Gm.); carbohydrate–50% (50 Gm.); fat–30% (13.3 Gm.); plus the following vitamins and minerals:

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Vitomin D (U.S.P. Units)..	125	30
Vitomin C, mg.	50	166
Thiomine, mg.	0.5	50
Riboflovin, mg.	0.6	50
Niacinomide, mg.	5	50
Colcium, Gm.	0.5	67
Phosphorus, Gm.	0.4	53
Iron, mg.	4	40
Iodine, mcg.	60	60

Vitomin E (Int. Units)	2.5
Pyridoxine, mg.	0.4
Vitamin B_{12}, mcg.	0.5
Colcium pantothenote, mg. ..	2
Sodium, Gm.	0.2
Potossium, Gm.	0.9
Copper, mg.	0.5
Mongonese, mg.	1
Fiber, Gm.	0.55

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references: (1) Nelson, W. E.: Textbook of Pediatrics, ed. 7, Philadelphia, W. B. Saunders Company, pp. 231-233, 1959. (2) Parrott, R. H., and Nelson, W. E.: *ibid.*, p. 759. (3) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (4) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (5) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960.

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1. Youmans, J. B.: Am J. Med 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med 25:662 (Nov.) 1958

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T. C. C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition J. B. Lippincott, Philadelphia, 1954, p. 264

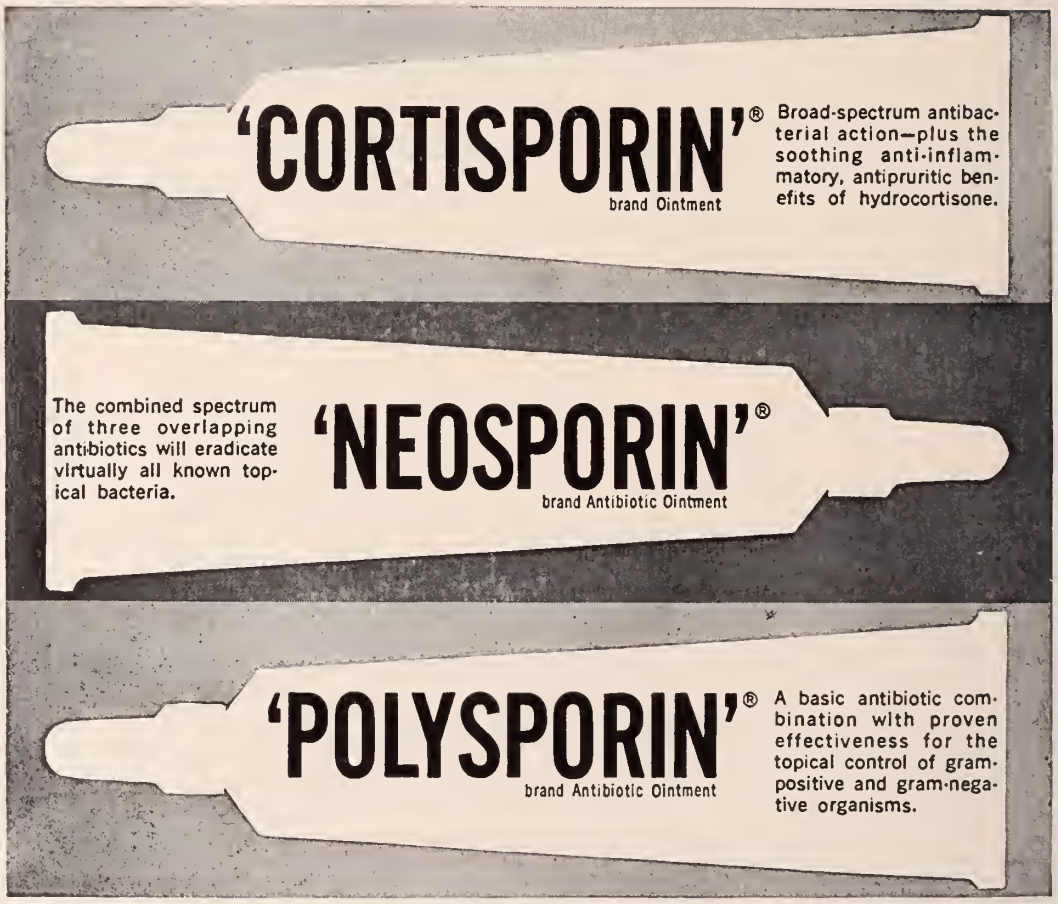
infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A. Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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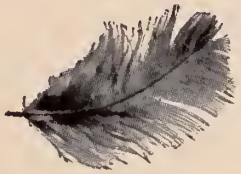
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References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy 18:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, In press. 3. Shaftel, H. E.: Clin. Med. 7:1841 (Sept.) 1960.

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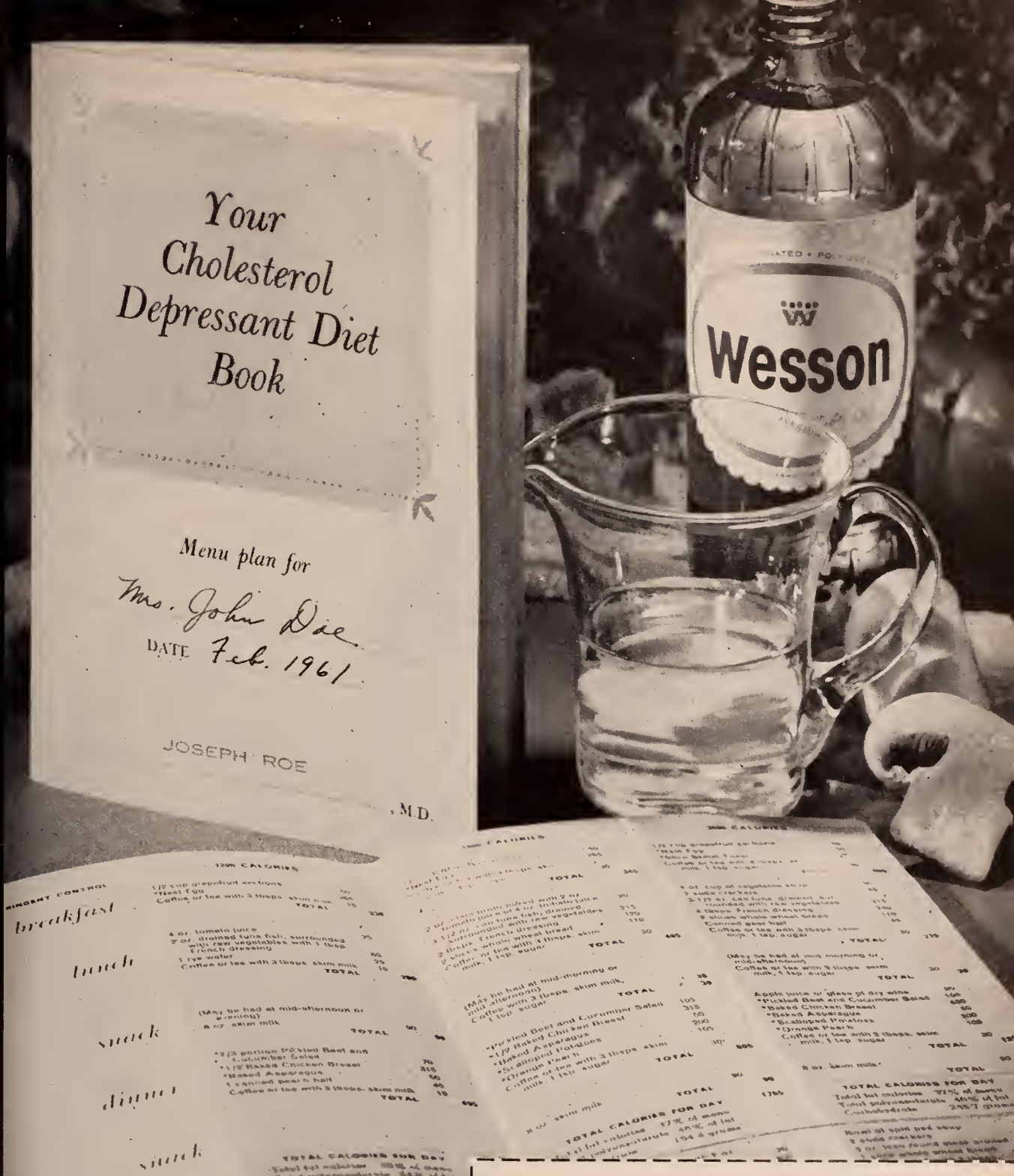
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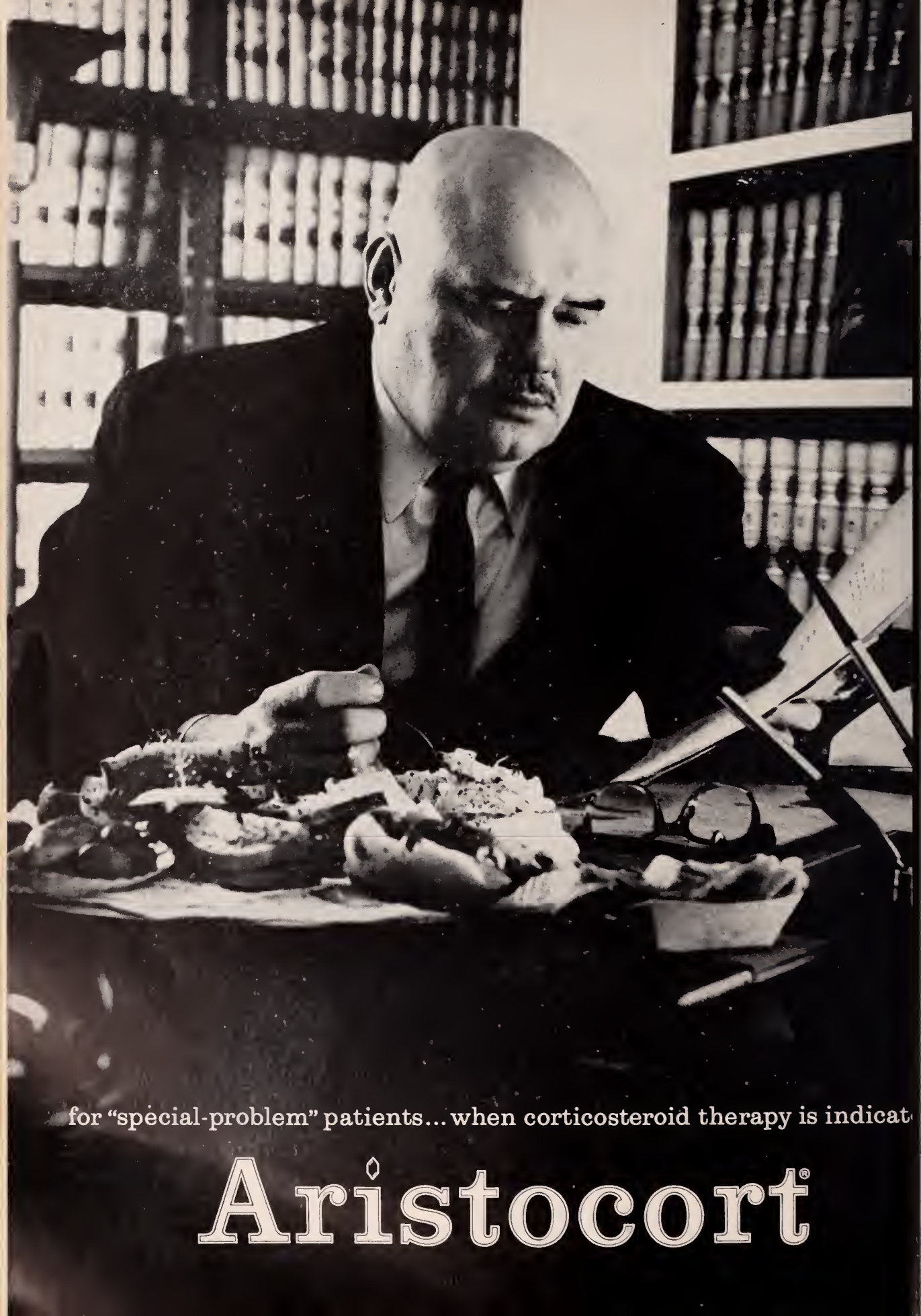
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No patient developed voracious appetite on triamcinolone. Preferable for the overweight person whose appetite is undesirably stimulated by other steroids. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

SPECIAL PROBLEM: EDEMA

Since it does not produce edema, triamcinolone is useful in rheumatoid arthritis patients with cardiac decompensation who need steroid therapy. (Hollander, J. L.: *J.A.M.A.* 172:306 [Jan. 23] 1960.)

SPECIAL PROBLEM: HYPERTENSION

Triamcinolone may be included among the currently available antirheumatic steroids having the least tendency to cause sodium retention. (Ward, L. E.: *J.A.M.A.* 170:1318 [July 11] 1959.)

Hypertension did not result from triamcinolone therapy. Existing hypertension was reduced sometimes. This may have been due to lack of sodium retention. (Freyberg, R. H.; Berntsen, C. A., Jr., and Hellman, L.: *Arthritis & Rheumatism* 1:215 [June] 1958.)

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of rheumatoid arthritis, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobomate combined with benactyzine (2-diethylominaethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Boteman, J. C. and Corlton, H. N. (50 patients): Meprobomate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beermon, H. M. (44 patients): The treatment of depression with meprabamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Touber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Londmon, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Popos, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprabamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

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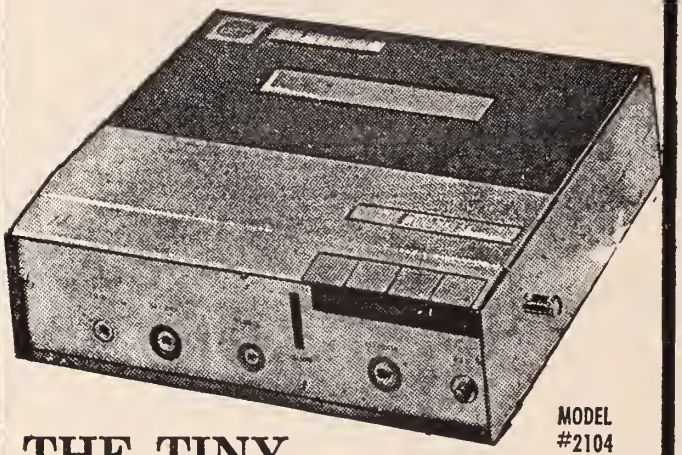
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Editorials • • •

"A Stench in the Ear"

In Ambrose Bierce's happy phrase, noise is a stench in the ear.[1] More than esthetics is involved, however. Noise is also a health menace. Compensation awards for industrially developed deafness now exceed $2,000,000 a year[2]—mostly attributed to unremitting or severely disrupting noise at work. Small animals can be killed by noises in excess of 160 decibels. And among human beings, 60 decibels can cause erythema and contractions of the muscularis of the stomach wall. Many experiments have shown that noise can reduce industrial efficiency.[3] Noise has a measurable physiologic effect: increased heart action, faster breathing, whipped-up muscle tone—all leading to extra energy drainage. Knudsen[2] estimates that 160 decibels can destroy a man's hearing. Persons exposed to jet plane noises (chiefly deck crews on carriers) suffer a hearing impairment that lasts for 15 to 24 hours after removal from the scene. In New York City alone, 26,000 citizens were fined last year for violating anti-noise ordinances. And in that year, the New York police recorded 1000 complaints *a day* (not a year—a day) about unnecessary or menacing noise. No one knows how much is spent on noise abatement. But in 1960, Americans spent 250 million dollars for acoustical tile alone.

We think of the health menace chiefly in terms of sudden explosive reports, or nonstop harsh noises. But today's household can constitute a ceaseless cacophony. Once it was home, sweet home—home, the repository of peace and quiet. Not any more.

The modern mechanized home is so noisy that a little quiet makes one's flesh creep. Doors slam, typewriters click, bells ring and refrigerators hum. The new bulbs look fine—but they hiss. Radiators whistle, the garbage dis-

1. Bierce, Ambrose: *The Devil's Dictionary.*
2. This and many other statistical items here come from "What You Hear Can Hurt You" by V. O. Knudsen, Ph.D., published in *Think* (The IBM magazine, February 1961).
3. Among them a study of F. W. Watkyns-Thomas included in his book, *The Principles and Practice of Otology*, London, 1932, Lewis. Knudsen also cites such studies as do Best and Taylor on page 1047 of their *Physiologic Basis of Medical Practice*, Baltimore 1945. Williams and Wilkins, ed. 4.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole number of Issues 684

VOL. 58, NO. 8 AUGUST, 1961

Subscriptions, $3.00 per year
Single Copies, 30 Cents

posal unit whooshes or roars, and air-conditioners counterpoint the rest of sound with their special murmur. Percolators gurgle, chairs creak and radio commercials scream and squawk. There is the bang-bang of TV westerns, and the peal of the door bell. The logs in the fire-place snap. If by some miracle there should be a blessed suspension of sound, the ticking clock becomes audible. Breakfast is preceded by the drone of the electric razor and is interrupted by the crackles in the cereal bowl plus the plop-plop of the pop-up toaster. The rasp and whir of the mixing machine punctuate the making of the Metrecal® luncheon. The dishwasher splashes and the drier rumbles. Housewives jabber, cats meow, peddlers hawk, and dogs bark.

Evidence is available [4] to indicate that a 14 per cent cut in noise levels (achievable with acoustic wall-board) will reduce stenographic errors by 30 per cent and machine operator's errors by 50 per cent. Believe it or not, noise abatement in one commercial organization was followed by a 37 per cent fall in the absentee rate.

As Knudsen has elsewhere [4] pointed out, the Good Lord provided the ass and the elephant with ear flaps that could partly close the external ear canal and thus muffle some sounds. But man, alas, was not so favored.

Physiologists say that a loud noise need not rupture an ear-drum to produce a harmful effect. It can raise intracranial pressure, whip up perspiration, stimulate muscle contractions, dry up the flow of saliva and shut off the gastric juices. Thus, noise actually interferes with digestion. Not well known—and not at all understood—is that sound energy can be converted into heat and thus wreak damage as if it were a thermal trauma.

We are so accustomed to noise that we are beginning to think that we really need it. A well-known tennis player once said that it improved his game to hear the sound of the ball pinging on the racket. Some golf players report that the crack of the club-head on the ball is a gratifying sound—and the same is true of baseball batters. Makers of noiseless typewriters were distressed to find that a 100 per cent noiseless machine reduced typing efficiency. The girls are so used to the clackety-clack that they feel uneasy if the typewriter makes no sound.

But enough is enough. We doctors are concerned about smog in the atmosphere and stenches in the air. Let us recognize that noise, too, can be a health menace.

4. Page 29 of the January 2, 1961 issue of *Time* Magazine.

Are Physicians Store-Keepers?

With the pressure for social security coverage, and the demand for price-lists (glamorized as "fee schedules") it was inevitable that sooner or later some one would argue that a physician's office was a store, selling services, just as a barber shop or a shoe-shine parlor was a store. In the September 15, 1960 New York State Journal of Medicine, the case of Sterling *v.* Lapidus (10 Appellate Division Second 180) was summarized as follows:

The Court was called on to determine on appeal whether, under the Emergency Business Space Rent Control Law, the space occupied by a physician on the street floor of a building is to be classified as a "store." If the space was found to be a store, then it would no longer be subject to "rent control" and could properly be decontrolled with subsequent substantial increases in rent. Two lower courts had ruled that such space was to be classified as a store.

The tenant, a doctor of medicine, occupied premises on the street floor of a Park Avenue apartment house. He had been in possession

for thirteen years, and following expiration of a lease in 1947 continued his occupancy as a statutory tenant. The physician never resided in the premises. The Court found that the space was occupied for professional use before he took possession. The tenant-physician under the terms of his lease was granted the right to occupy the premises for the practice of his profession. There had been nothing which showed that the landlord ever treated the space as a store. Access to the office was through the main lobby of the building and no means of direct entrance from the street was provided.

The landlord argued that the physician occupied a store because the premises were located on the street floor and he rendered services in the ordinary course of business. The Court rejected this argument, saying: "A store is an establishment at street level which purveys merchandise for consumption, use, or adornment, ranging from doughnuts to diamonds, or renders services which run the gamut of needs from shoe shines to automobile repairs. We cannot accept a general definition that classifies members of the learned profession of medicine as engaging in 'the rendition of services, in the ordinary course of business, or commerce.' Assuming the propriety of that classification when barbers were united with the company of surgeons by an act of parliament with the former confined to bloodletting and extraction of teeth, it became inappropriate after 1745, when parliament severed the barbering from surgery and gave the latter the status it still enjoys."

The Court continued: "The term store, in the natural and common acceptance of the term, is not applied to space occupied by a physician. Certainly long before the enactment of the business and the commercial rent laws, one did not seek medical treatment by entering store premises. For example, it is scarcely imaginable that the landlord ever said that he had gone to the store for a medical examination. In modern times doctors usually maintain offices either in private houses in which they reside; in multifamily structures, usually but not exclusively on the ground floors; or in office buildings, some wholly devoted to medical practitioners. It must be assumed that, in enacting the rent control statutes pertaining to stores, the Legislature was fully aware of this custom."

The Court also observed that the premises occupied by the physician were in a class A multiple dwelling located in a residence use district as defined in the zoning ordinances of New York, and that under the zoning laws, in areas where stores are prohibited, space occupied by physicians for professional use and located on the ground floors of class A dwellings is recognized.

For all the years the physician occupied the premises no question ever had been raised that his office was a store maintained in violation of the zoning regulations. The Court noted that its attention had not been directed to a single instance among the thousands of physicians' offices similarly situated, where a charge had been made or sustained that occupancy was in violation of the proscription against conducting a business.

The Court concluded its decision by saying: "To classify all physicians' offices as stores, merely because they are located on street level, would subvert the purpose of the rent laws and produce a harsh and unjust result never intended by the Legislature. Were we to conclude that doctors' offices on street level are subject to decontrol because they are stores, we would subject that class of tenants to demands for exorbitant rents."

It then unanimously reversed the determination of the lower courts and directed dismissal of the landlord's action.

While justice (and common sense—and professional dignity)—finally triumphed, the alarming thing is that two lower courts actually held that the doctor's office *was*, in legal terms, a "store" because it was on the ground floor and purveyed services. Our concern with some of the economic aspects of practice is understandable—but there is the danger that if we talk and act like tradesmen, the law may finally so classify us.

Ralph M. L. Buchanan, M.D.

Phillipsburg

Prescription for Survival*

A Journal like this must necessarily fill its pages with suggestions on the art and practice of medicine. As welcome as a fresh breeze is the occasional document like this with emphasis on the spiritual and its resounding call to idealism.

Time and the developments of life have a way of suddenly overwhelming one, no matter how thoroughly he has been forewarned of their drift and direction. Though, since my election to the office of second vice-president, I have known that in the normal sequence I should advance to the presidency, nevertheless it is with a sense of awe and shadowy disbelief that I stand here today to assume, by your graciousness, the dignity and the duties of office as the 169th president of The Medical Society of New Jersey. My prayer is that God may give me the judgment and ability to measure up to the demands of this high office. My pledge to you, to all our members, and to the people whom we unremittingly serve is . . . I shall do my conscientious and devoted best.

I have found myself looking back with an almost wistful yearning to the dear, dead days—not, I hope, necessarily beyond recall—when the chief obligations imposed upon the president of this Society were to preside at the annual meeting and to deliver a presidential address. In remote other days, the presidency was an office of leisurely dignity, levying only in limited measure upon the time and energy of the honored incumbent. Its atmosphere was one of serenity, conducing to the indulgence of social amenities, and affording ample time for the cultivation of cultural interests . . . Those were days of relative peace, but our days are days of bitter and deadly war.

In consequence—as I have witnessed in the last several years—today the president of the Society is a man under pressure, never free of challenging demands upon his abilities and his energies. He is, at various times, policy-maker, spokesman, negotiator, controversialist, diplomat, strategist, and field-general. Our Society has been fortunate in the men who have gone before me. It shall be my aim and purpose to serve as well and ably as they have served. I hope that I shall succeed—no matter what the cost in time and effort—so that you may be pleased, and the true good of our people and of our profession simultaneously advanced.

I have said that these, our days, are days of bitter and deadly war. It is not singular for a doctor of medicine to find himself cast as a warrior. That is his natural role. But customarily he wages war against those forces that threaten the health and the life of his fellowmen. To this warfare all men and women of medicine have always been dedicated. In waging this war they have, through the crowd-

*Inaugural Address, presented at the 195th Annual Meeting, May 15, 1961.

ing years, been splendidly victorious. In this war they continue to be vigorously and effectively engaged—with a fruitfulness that is triumphantly evident in the longer life and better health that our people in general enjoy today. The familiar old war against disease and death is, therefore, unremarkable, except in the fact that it is marked so consistently with victories.

It is of the new war that I would speak, and concerning which I would issue a call to arms. This war involves us more as citizens than as physicians of the United States. To its prosecution we should address ourselves with united and total energy. Upon its outcome depends not only the life and character of the practice of medicine in the United States, but the life and character of the very nation itself.

The new war is new only in the sense that it critically challenges us and nearly all the other peoples of the world today. It is in reality a pandemic outbreak of the war between freedom and slavery in which our forefathers so mightily and admirably engaged. It has been forced upon us—and upon all the rest of the world—by the determination of Soviet Communism to subjugate and enslave the entire world. The goal has been openly and loudly proclaimed by successive groups of Communist leaders. World domination is their confessed objective—the establishment of the supreme state in all the countries of the world, the triumph of the state as absolute and sovereign, and the debasement of all people everywhere to the status of absolute dependents and servants of that sovereign, tyrannical state!

This goal can be realized only through the death of individual liberty. Already in vast areas of the world the fell deed has been accomplished. In Russia, Poland, Hungary, Latvia, Lithuania, Czechoslovakia, Germany, Jugoslavia, Red China, Cuba . . . personal freedom is dead, and despotism holds sway.

In other countries the pernicious process is well advanced. The free nations of the world grow constantly fewer and more enfeebled. The United States of America and the governments which are allied with it alone retain the power to resist the devastating dragon of despotism, alone sustain the hopes of all the people of the world. The struggle is truly titanic. The eventuation will be decisive for civilization as a whole—and for centuries to come.

President Kennedy has recognized and summarized the situation in words of crystal and desperate clarity. Recently he declared: "The complacent, the self-indulgent, the soft societies are to be swept away with the debris of history. Only the strong, only the industrious, only the determined, only the courageous, only the visionary who determine the real nature of our struggle, can possibly survive."

This, then, in essence is the new war—to which as citizens first, and only secondarily as physicians, we are called. This is the war that is upon us! From it there is no escape even for those so base as to desire it. It offers no choice to us—or to any other people—except to win and live, or to lose and perish.

No war is won by armaments and missiles alone. If there is a determinant of invincibility, it lies in the morale of a people. It is characterized by a valorous and indomitable will to win that resides in each stalwart breast, so that each individual heart becomes a fortress impregnable to, and defiant of, the enemy. It bespeaks a flaming spirit in every citizen which will count no personal sacrifice too great for national victory. It was that spirit which won our freedom for us originally. It is that spirit alone which will preserve that freedom now.

It is the realization of this fundamental and irreversible truth that has led us, as citizens and as physicians, to oppose politically-sponsored social legislation that in its ultimate effect would vitiate and shatter the spirit of resolute independence and self-reliance of the American citizen.

It cannot be denied—the record demon-

strates it incontrovertibly—that social concepts and programs which originally were embraced to help people to help themselves—and thus to preserve in them a spirit of independence and self-reliance—have been progressively distorted and modified so as to thwart and stifle those saving attributes in our citizens and to develop in them instead a despicable eagerness to depend upon and rely upon government.

The result has been to produce a disinclination on the part of many of our citizens to stand on their own feet, to live their own lives by meeting and solving their own problems, to help themselves, and thus to remain free. Rather they have been misled into wanting to be helped, sustained, and provided for—all at no cost to themselves they foolishly think, disregarding the fact that as taxpayers they must pay—and pay dearly—for all that government provides; and that as citizens for these debilitating benefits they must barter the gold of their personal liberty.

With the fact that all these changes are economically hazardous to the nation at a time when economically it needs to be most sound, I am not in these remarks today especially concerned, though I certainly do not mean to minimize their significance. What I want especially to deplore is the fact that the deterioration and ultimate loss of the spirit of independence and self-reliance in our citizens would spell the death of the morale—of the fortress spirit—of our citizens, without which we cannot hope to withstand the philosophic guile and the martial might of those who would enslave us.

President Kennedy knows this. "The complacent, the self-indulgent, the soft societies are to be swept away with the debris of history," he warns. But what he seems not to realize is that many of the enervating and debilitating social legislative programs against which I have been inveighing are in large part supported by him and his administration. Is it consonant with our needed strength as a people to encourage citizens—well able to take care of themselves and their own—to become dependent instead upon the government? Doesn't that lead such people to become complacent, self-indulgent, and soft?

We in Medicine think that it does. That is why we want government—at any level—to supply the needs of only those people who cannot do so for themselves, and only to the extent to which they are thus incapable. We know that a citizen must be strong to survive, and that the strength of a nation is the sum of the strength of all its citizens.

The present phase of the new war in which we are all engaged is being fought as much in the hearts of the people of our country as in any theater of actual combat anywhere in the world. As a people we must see to it that we are strong, industrious, determined, courageous, and realistically visionary—as the President says we must be, if we are to have a chance to survive. That means we must stamp out in ourselves any self-serving tendencies that will diminish self-discipline and self-exaction in us, and that will leave us in our characters less admirable or strong.

To preserve industriousness, we have to be willing to work, arduously and well, to build the worthy things that will repay us for our efforts as mere money never can. To be courageous, we must learn to view the vicissitudes of life not as problems (as so frequently now we do) but as challenges, to be optimistically evaluated and vigorously met. To be visionary, we must learn once more to look beyond the proximate, the material, the pragmatic, and to rediscover that Truth alone can make us free, and only Justice can keep us so.

In a time of national crisis such as now exists, it is the duty of every citizen to be his best and to give his best for his country. The President has urged this duty upon us all. "Ask not," he has said, "'What can my country do for me?' but rather, 'What can I do for my country?'" What can I do for my country in all the ways in which I have power to serve? What can we do in our dual role as citizens and physicians?

We can, as individuals, rededicate ourselves to the ideals of freedom, justice, honor, service, and love. We can work to demonstrate to all the world, by our attitudes and accomplishments, the superiority of our system of free enterprise in terms of the general good, prosperity, order, and peace. We can encourage and stimulate in all with whom we come in contact appreciation of the blessings and advantages of living as free men, under a balanced and restrained system of government. We can work with unflagging zeal to preserve our freedom and our government from corrupting change. Most important of all, we can, as individuals, live ourselves—and encourage our fellow citizens to live—in eloquent conformity with the fundamental moral and spiritual laws which alone can insure to men a decent, dignified, and peaceful society.

Together, we can work for the success and survival of our way of life, our system of government, our civilized society.

We can be guided in all that we collectively do by one paramount criterion—the real good of our country. We can discourage the too widespread tendency to put personal advantage before the general good and encourage instead a flaming spirit of unity and brotherhood.

We can, in short, together forge a new secret weapon—such as atheistic Communists can never produce—which may yet avail to keep us safe and free—an indomitable will to win, that springs from a genuine love of our country and of one another, fortified and sustained within us by the fear and love of God.

In this spirit we should—we must—wage our war, sustained by the knowledge of the worth and rightness of our cause, realizing that every man best fulfills his duty to himself by fulfilling his duty to God, his country, and his fellowmen.

In such a war, for such a cause, waged in such a spirit, it is almost a pleasure to fight. I am happy to be in it with you.

8 Market Street

Tribute to Dr. Evans

Philadelphia Medicine in its July 7, 1961 issue referred to J. Lawrence Evans, 3d, son of the former chairman of our Publication Committee. "He is" comments *Philadelphia Medicine*, "a lateral descendant of George McLellan, founder of the Jefferson Medical College. J. Lawrence Evans, 3d is the fourth member of the Evans family to be graduated from Jefferson and the tenth McLellan to have been associated with the institution. His grandfather, J. Lawrence Evans, Sr., is administrator of the North Hudson Hospital, Weehawken, N. J.; his father, J. Lawrence Evans, Jr., is a psychiatrist who practices in Englewood, N. J.; and his uncle, Robert L. Evans, is director of medical education at the York (Pa.) Hospital."

Francis I. Tomlins, M.D.

Ridgewood

Medical Screening for High School Football

In screening boys for football, the family doctor must not abdicate his authority to the team physician. Just how the family doctor can discharge that responsibility is indicated in this unusual article.

Before he engages in football, a player should have a meticulous medical examination. This screening examination should be divide into four sections: (1) Medical history; (2) Complete physical examination; (3) Laboratory aids and (4) Preventive medical measures.

MEDICAL HISTORY

Role of the family physician: Ideally the medical history should be supplied by the family physician to the team physician. Also, the football candidate should have a complete physical examination by his family physician sometime during the summer months.

Any injury or illness, old or new, that might have a bearing as to the physical fitness of the youth, should be reported in writing to the team physician before September 1.

Role of the team physician: The team physician does not have the time to sit down and take a detailed medical history on each candidate at the screening examination. It is utterly impossible to do this on 50 to 75 young men examined each day, or until the candidates from the 9th, 10th, 11th, and 12th grades have been examined.

However, the team physician has the composite school medical history and past examination records of each youth at the time of this examination. He should do a running "medical history conversation" with the student during the examination and so record any new history in the school records. Sometimes the student "forgets" to relate the facts concerning a recent illness or injury.

Our committee has developed a practical questionnaire* to be sent to the family physician of each football candidate to aid in obtaining this medical history.

PHYSICAL EXAMINATION

The family physician has a prime role in notifying the team physician as to any physical abnormality that might be limiting in a "contact sport."

The team physician should have his examining room so organized that no time is wasted waiting for the student to undress or dress. The candidate should be undressing in an adjoining room so he can report to the physician only in shorts.

The medical examination of each part of the body then begins. General physical stature is first noted; for example, the slender, long-limbed boy is usually more injury-prone than a stocky boy.

*The questionnaire is appended to this article. The responsible committee was the Committee on Athletic Injury Prevention of the Bergen County Medical Society.

Head: Checked for any abnormality. A history of repeated concussions should be disqualifying. "Repeated concussions" is too loose a term. If a youth has had three "minor concussions" it is questionable if he should ever be allowed to play football. History of a skull fracture should be disqualifying, although there may be some skull fractures without complicating hemorrhage or blood clots that are so mild as not to be disqualifying.

Neck: Examination for abnormal lymph glands. Is the neck flexible or rigid? Is the neck long, average, or short? It is questionable if any boy with a very long neck should play football, as his neck is vulnerable to injury.

Eyes, ears, nose, and throat: Eyes are examined for gross disease and reflexes checked. Does he wear contact lenses during a football game? Does he have loss of or seriously impaired vision in one eye? If so, he should not play football. Has his vision been checked by his physician or by a school examination? Sometimes the athletic ability of a boy can be increased in all sports by proper correction of defective vision.

Routine examination is made of ear canals and drums; also examination of nose and throat.

Chest: Routine examination is needed to rule out pulmonary disease.

Heart: Blood pressure and routine examination are made to rule out heart or cardiovascular abnormalities.

Abdomen: Routine examination is made to rule out any enlarged or displaced organ.

Genito-urinary: A youth with only one kidney should not play football. Special care is needed in ruling out hernias: if any irritation is present in the groin area, specific instructions are given to see his family physician for treatment and to return with a written note that he is under treatment. Undescended testicle or loss of one testicle should be a disqualifying defect.

Coordination: Simple tests that may be performed quickly give some idea as to his coordination.

Extremities: Routine examination is necessary with special emphasis on any old injury, such as a knee injury incurred during the past football season.

Joint injuries which have not been adequately repaired by surgery due to excessive damage should disqualify the boy from football.

Feet are examined for fungus infection.

Reflexes are swiftly tested.

During the complete examination any infections of the skin, presence of a cold, faulty posture, or poor muscular development are noted. If there is a history of a "bleeding tendency," the youth should be disqualified.

With experience, all of this can be performed in a relatively few minutes per boy.

LABORATORY AIDS

1. During the summer examination performed by the family physician, a urinalysis, especially for sugar, should be done, and the results given to the team physician.

2. *Chest x-rays or Mantoux tuberculin test*: Being part of the school health program, these should not cause any problem, as each candidate from the 10th, 11th, and 12th grades has been screened preceding September 1. It is recommended that the eighth grade students who will be football candidates in September of their ninth grade be Mantoux-tested in June of their eighth-grade year.

3. *Complete blood count*: This will rarely pick up an anemia or blood disease as these candidates are in excellent health; nevertheless, it should be incorporated in the family physician's summer examination, and the results passed on to the team physician.

PREVENTIVE MEDICAL MEASURES

1. It should be mandatory that each candidate be fitted with a dental mouthpiece. By 1962 this will be required of all football players. Not only is this important from a cosmetic and economic point of view, but it can definitely prevent and minimize the seriousness of a cerebral concussion.

2. Each candidate should have a tetanus toxoid booster during the family physician's summer examination; or at least have had one within the year.

3. Each candidate should have completed his poliomyelitis inoculations.

CONCLUSION

1. A method of pre-season football medical screening is reviewed. It is evident that friendly cooperation between the family physician and the team physician is essential, not only for the pre-season screening but during the entire football season.

2. There is general agreement that a boy who has lost one of a paired organ should not compete in football. Joint injuries not adequately repaired and repeated concussions are disqualifying defects.

3. A football player should tell his coach or team physician of any injury sustained before or during the football season. A player owes it to himself, his parents, his team, his coach, and his school to report correctly his physical fitness.

I wish to thank the following for their opinions on the subject of pre-season medical screening:

Philip W. Mallory, Colonel, Medical Corps, U. S. Military Academy
Asbury Coward, Captain, U. S. Naval Academy
H. R. McPhee, M.D., Princeton University
Geoffrey W. Esty, M.D., Consultant in School Health Education, State of New Jersey
O. W. Dayton of Yale University

97 Madison Place

FOOTBALL CANDIDATES' PRE-SEASON QUESTIONNAIRE

To be completed by family physician and returned to the team physician

Name ..... School ..... Age .. Ht. .. Wt...

1. *Past Concussions*	Yes†	No
Past skull fractures	Yes†	No
Epilepsy or other convulsive disorders	Yes†	No
Neck injury	Yes†	No
2. *Defective Vision*	Yes†	No
Glasses or contact lenses for athletics?	Yes	No
Loss or seriously impaired vision in one eye?	Yes	No
3. *Chest—Cardiovascular—Abdomen—Any defect?*	Yes†	No
4. *Hernia*	Yes†	No
Undescended or loss of one testicle	Yes	No
5. *Joint Injury Not Healed or Repaired*	Yes†	No
6. *Any Other Defect*	Yes†	No
7. *Urinalysis—negative for sugar*	Yes	No†
Complete blood count—results		
8. *Tetanus Toxoid Booster* within past year (if no, recommend booster before football season)	Yes	No†
Poliomyelitis Inoculations completed	Yes	No†
9. *Fitted with Dental Mouthpiece* by dentist	Yes	No†

†*Please explain—on reverse of form.*

....

Family Physician's signature and date

Juvenile Arthritis

The author* presents results of long-term use of prednisone and prednisolone in patients with juvenile rheumatoid arthritis. Satisfactory relief of pain and stiffness was obtained in 80 per cent of patients, but only 20 per cent had remission of the disease during treatment. Objectively, 40 per cent were unimproved or became worse. The course of juvenile rheumatoid arthritis can often be predicted at onset. The disease may be benign and last but a few weeks. It may remit spontaneously or with the aid of simple medication. A real problem is presented when the patient pursues a downward course toward complete invalidism. It is in such cases that steroid therapy is justified.

*Harnagal, E. E.: 1959 Journal of Diseases of Children, 97:426.

H. H. Goldstein, M.D.
Elizabeth

The Dissolution of Staghorn Calculi*

One in a Solitary Kidney

The dream of somehow dissolving stones has always enchanted physicians and surgeons. Here are some promising results in urinary calculi.

Calculi often occur in the renal pelves of patients who are poor surgical risks. Every urologist wishes that there were a practical solvent for such calculi. While such solvents do exist, those that show marked dissolution of stones are too toxic or irritating. Recently a product has become available which, it was asserted, could dissolve "soft" stones; that is, those of tribasic calcium phosphate, magnesium ammonium phosphate or calcium carbonate composition primarily, with little or no irritation and a complete lack of toxicity. Last summer, Mulvaney [1] reported on a number of cases in which this solvent, Renacidin,† appeared to be effective in removing a number of calculi from the pelvis.

It was ascertained [6] that Renacidin† contained about 65 per cent of edible organic acids taken from the group: gluconic, citric and malic. All of these are non-toxic food acids. These are present primarily in the form of the lactones, anhydrides and acid salts. A small amount (less than 0.5 per cent of the product) is composed of aryl-carboxylic acid as benzoic. The balance consists of neutral salts which are water soluble with less than 0.5 per cent calcium salts.

Recently I used Renacidin® in a 10 per cent solution for the first time. Because of the unusual nature of the first case and the condition of the patient, as well as the result obtained, I felt that a report would be of interest to physicians who might encounter similar cases.

CASE ONE

A 68-year old male was admitted to the Alexian Brothers Hospital on November 30, 1960 with gross pyuria. There were no other symptoms. X-ray revealed a large staghorn calculus of the right kidney.

Past History: Parkinsonism began several years ago. This has become progressively worse.

Physical Examination on admission was essentially negative except for the Parkinsonism. The abdomen was flat; there were no masses nor areas of tenderness and the right kidney was not felt. Blood pressure was 160/90.

Present Illness: He passed a calculus in June 1948. X-ray taken shortly after this was negative for calculi. In 1950, a repeat roentgenogram was again negative for stone. In 1951, he had a left renal colic and x-ray showed a low-lying ureteral calculus on the left side. Cystoscopy at this time revealed a pin-point ureteral meatus. A left ureteral meatotomy was done with passage of the calculus. In 1952, the patient had a recurrent left renal colic. X-ray then showed a fairly large ureteral calculus on the left side. This was removed by ureterolithotomy. Nine months later, a left nephrectomy was done for calculus pyonephrosis of the left kidney. In 1956, he suffered acute urinary retention due to prostatic hypertrophy and a one-stage suprapubic prostatectomy was done. Re-

*From the Department of Urology, Alexian Brothers and St. Elizabeth Hospitals, Elizabeth, N. J.

†Renacidin® is a proprietary tradename for a mixture of the anhydrides, lactones and salts of a group of multivalent food acids. It is available as a soluble powder. The preparation is a product of the Guardian Chemical Corporation of Long Island City, N. Y.



Figure 1. Case 1 (a) Film showing renal calculus with catheters in place before starting perfusion with Renacidin.®



Figure 2. Case 1 (b) 29 days of continuous perfusion. No calculus is visible.

covery was uneventful. In 1957, he had a right renal colic. A right ureterolithotomy was done for a calculus in the lower right ureter. In January 1959, the patient was passing stones frequently but without undue pain. X-ray at this time failed to reveal any calcareous deposits in the right kidney. On November 30, 1960 it was found that his urine was loaded with pus and that there was a huge staghorn calculus of the right kidney measuring 3½ by 2½ inches. On December 2, 1960, a number 5 and number 6 ureteral catheter were placed side by side in the right pelvis and 10 per cent Renacidin®† was started as a continuous drip at about 30 drops a minute. This was continued for three days when the catheters were inadvertently pulled out. It was impossible to replace either catheter in two cystoscopic trials but on December 14th, a number 5 catheter was placed in the right pelvis. It was then decided to allow the ureter itself to double as the second or outflow catheter. A Foley catheter was placed in the bladder for drainage and the Renacidin®† was started and allowed to flow at a steady rate of about 40 drops a minute for the next 29 days. During this time both the ureteral and Foley catheters functioned well. The course of the dissolution of the stone was carefully followed by frequent x-rays. On January 12, 1961, when the radiologist reported the absence of calculi in the right kidney, the Renacidin®† was discontinued.

Laboratory Studies: On admission, blood urea nitrogen was 41. The urine was negative for sugar and acetone, but albumin was 2 plus. On January 10, 1961, the blood urea nitrogen was 104, creatinine 6.5, carbon dioxide 20, and calcium 6.

Progress: On January 8, 1961, the patient became lethargic and lapsed into uremic coma. The blood urea nitrogen and nonprotein nitrogen were increased to 104 and 120 and the calcium was 6, while potassium was 8.8. Potassium exchange resin was administered with little benefit and although it was realized that there was probably very little renal cortex left, peritoneal dialysis was done. After 36 hours of dialysis, the blood urea nitrogen had dropped to 41; the calcium was 9 and the potassium was 4.2. Potassium on the following day came down to 3.5. The patient was definitely more alert, intravenous fluids were stopped and he was allowed to sit up in a chair. Progress continued favorably and on January 25, 1961, the calcium was 8, potassium 3.7, blood urea nitrogen 53 and nonprotein nitrogen 62. Specific gravities on the urine showed a range of 1.010 to 1.020. The patient was discharged on January 28, 1961.

CASE TWO

A 71 year-old woman was admitted to the St. Elizabeth Hospital on March 2, 1961 with pain in the right flank.

Past History: Fractured vertebra in 1960. Ulcers on both legs 5 years ago.



Figure 3. Case 2 (a) Pyelogram showing filling defect caused by soft stone filling the renal pelvis.



Figure 4. Case 2 (b) KUB showing no evidence of calculus.

Present Illness: Onset dates back about five months prior to admission with pain in the right flank accompanied by chills and fever. This series of symptoms recurred four or five times.

Physical Examination: Examination on admission showed the abdomen to be flat. There were no masses or areas of tenderness. The kidneys were not felt and there was no Murphy sign on either side. The chest was negative and the heart and blood pressure were within normal limits. Both legs showed many tortuous varicosities and there were the scars of previous ulcers on both legs.

Hospital Course: On March 3, 1961, an intravenous urogram showed a suspicious shadow on the right side. Retrograde pyelography revealed a semi-radiolucent calculus occupying the entire pelvis of the right kidney. A number 6-F catheter was passed to the pelvis of the right kidney. Since all attempts to pass a second catheter alongside this one were fruitless, it was decided to use only one catheter for the perfusion. The patient was started on Renacidin® on the same day of cystoscopy with a flow of about 40 drops per minute. This was continued with good tolerance on the part of the patient until March 7, 1961. On the morning of March 7, 1961, a routine kidney-ureter-bladder x-ray showed no evidence of calculus. This was 3½ days after the start of perfusion with Renacidin®†. At 1:30 p.m. on March 7, 1961, the patient suddenly gasped for breath, became cyanotic and expired.

At *autopsy*, it was ascertained that death was due to a massive pulmonary embolus originating in the left leg. The bladder showed a mild degree of cystitis and contained about 10 cubic centimeters of brownish "mud." The left ureter and kidney were normal. The right ureter was thick and dilated, showing a moderate degree of ureteritis. The right kidney was densely adherent to the fatty capsule. The kidney capsule itself stripped with difficulty and when the kidney was opened, the pelvis was filled with thick "mud" similar to that found in the bladder. This "mud" was not gritty but was, rather, smooth and creamy in consistency. In the center of the pelvis was a soft spongy mass about 2 centimeters in diameter, apparently representing the organic framework of the disintegrated calculus.

Laboratory Studies: On admission the urine showed a moderate number of pus cells with some clumping and a few red blood cells. Blood urea nitrogen was 18.5, glucose 110. Culture of the urine showed a gram negative rod sensitive to Chloromycetin®.

These case histories illustrate the possibilities inherent in some of our more recently available drugs when they are utilized to their fullest potentialities in the face of the direst of odds. Incidentally, this study also indicates the complete lack of toxicity of Renacidin®,† used for 29 consecutive days in a patient for

whom the prognosis of recovery was extremely poor at the onset of treatment.

When two catheters were used to perfuse the kidney, the "mud" which formed frequently blocked the return flow catheter which required frequent irrigation. When one catheter was used and the ureter itself doubled as the return flow catheter, drainage was free and without irritation into the bladder. When the perfusion bottle containing the Renacidin®† is kept about two to two and one-half feet above the level of the patient, there is little or no danger of pyelovenous backflow because the intrapelvic pressure exerted by this column of fluid is not great enough to produce any. On the contrary, when the intrapelvic pressure equals the weight of this column of fluid, the perfusion ceases to flow. When this occurs, it usually means that the pelvis is filled with "mud." Gentle irrigation of the catheter with normal saline will generally loosen up the pelvic mass and peristalsis will then clear the pelvis and the perfusion will start again. Keeping the ureter flaccid by the use of an anticholinergic also has merit. This makes for better ureteral drainage. Keeping the solution warm by wrapping an electric heating pad around the bottle increases the solvent action of the Renacidin®† but care should be taken to prevent the solution from getting too hot by keeping the heating pad control at the "low" point. The Foley catheter adequately drained the bladder without obstruction from the "mud" although it was found advantageous to irrigate the bladder about once a day.

CONCLUSION

RENACIDIN®† was found effective in the dissolution of staghorn calculi in two cases. One was a staghorn calculus in a solitary kidney. This required 29 consecutive days of perfusion. The second case, having come to postmortem, allowed study of the results of perfusion after 3½ days.

318 West Jersey Street

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John A. Strazza, Jr., M.D.
Bloomfield

Reducing the Dosage and Risks of Phenylbutazone*

Experiences with a Sustained Action Salicylate

The risks of phenylbutazone, Dr. Strazza suggests, may be reduced by administering a mixture of salicylic acid esters, one of which acts slowly, and one of which acts swiftly.

In the conservative management of rheumatoid arthritis and osteoarthritis, the initial effort is to provide relief of pain; but attention must also be given to mechanical problems. Rest, diet, counseling and exercise are simple measures which, though often helpful, are sometimes neglected.

Salicylates are the analgetics of first choice. They offer greater freedom from both the manifest side effects and the hidden and more serious hazards of phenylbutazone and corticosteroids. Sometimes, however, we must use one or the other of these potent drugs to give relief from the intense and crippling pain of some severe arthritic conditions.

When the patient reports that pain is only incompletely lessened by salicylates, it may be found that the salicylates do provide relief during a large part of the day. Patients are prone to consider pain recurrence as proof of total failure of the treatment. Yet questioning may show that considerable pain relief was provided. Bayles,[1] Batterman,[2] and others have found that, in many arthritic patients, recurrence of pain is correlated with a decline in salicylate blood level due to the rapid elimination of salicylate by the kidney. When pain recurs between salicylate doses, and in the morning, the inadequacy of the therapy may be caused by the failure to maintain adequate salicylate blood levels rather than the failure of salicylates to provide the degree of analgesia needed.

When the pain is, in fact, of such intensity that phenylbutazone or corticosteroids are justified risks (and after adequate improvement is obtained with them) the dose should be decreased to the minimum effective level. Minimal dosage provides two advantages: it reduces risks; it provides an additional therapeutic margin which can be utilized if the medical condition warrants.

This study was conducted to determine if the more persistent [3] and better sustained salicylate analgesia [4] reported with a long-acting salicylate preparation† would permit discontinuance of phenylbutazone or a significant reduction in its dosage requirements in patients already on minimal maintenance dosage.

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*From the Arthritic Clinic of St. Mary's Hospital in Passaic, N. J.

†The drug used was an uncoated tablet consisting principally of 2½ grains of aspirin and 7½ grains of salicylsalicylic acid. The preparation in this study was the Sherman Laboratories brand, tradenamed Persistin.® These two esters have different absorption rates, which accounts for the long-lasting analgetic action.

1. Bayles, T. B.: Medical Tribune, 14:14 (January 9, 1961).

2. Batterman, R. C.: Postgraduate Medicine, 25:97 (1959).

3. Beigeleisen, H. I.: Medical Times, 85:866 (July 1957).

4. Denson, L. J. and Thompson, W. R.: Journal of The Medical Society of New Jersey, 57:314 (March 1960).

The study was conducted on 96 private and clinic patients referred to the Arthritic Clinic of St. Mary's Hospital, Passaic, N. J. Of the 96 patients, 38 were males. Their ages ranged from 27 to 73 years. Median age was 54 and average duration of the illness was 5.4 years. There were 32 with rheumatoid arthritis; 34 had osteoarthritis and 19 mixed arthritis (osteoarthritis superimposed upon rheumatoid). Five patients with recurrent bursitis and 6 with recurrent sacro-iliac joint pains completed the group. Six patients also had diabetes. Seventy had been given corticosteroids for varying periods prior to the study.

Severity of the arthritis was rated as follows:

Mild: early, minimal structural damage, with pain that was a "nuisance" but not severe enough to interfere with the function of an involved joint.

Moderate: evidence of structural damage with pain contributing to altered function of an involved joint.

Severe: advanced structural damage with extreme pain contributing to the loss of most functions of an involved joint.

Severity of the pain was the criterion for classification of the bursitis and sacro-iliac cases.

TABLE 1.

ARTHRITIS

Patients		Mild	Moderate	Severe
32	Rheumatoid	9	13	10
34	Osteoarthritis	10	16	8
19	Mixed arthritis	6	7	6
—		—	—	—
85	Sub-Total —Arthritis	25	36	24

OTHER CONDITIONS

5	Bursitis	—	—	5
6	Sacro-iliac pain	2	1	3
—		—	—	—
96	Totals	27	37	32

Complete physical examination was supplemented by periodic laboratory studies. These were: urinalysis including tests for bile constituents; complete blood count; determination of the blood sugar; blood urea nitrogen; sedimentation rate; and examination of the stool for occult blood.

Patients were seen weekly for three months and every two or three weeks thereafter. The investigation was started two years ago and the patients in this report were observed for at least six to 12 months.

The salicylate preparation investigated (mixed salicylic acid esters†) is supplied as a ten-grain tablet containing 7½ grains of salicylsalicylic acid and 2½ grains of acetylsalicylic acid. These tablets are free from sodium and sugar.

The salicyl ester of salicylic acid has a nonsolubility in gastric secretions which is comparable to that of phenyl salicylate (salol). This was formerly the most widely used material for the enteric coating of tablets. Hence, the tablet is uncoated as it has intrinsic "enteric" properties. Its low solubility provides relative freedom from gastric irritation and intrinsic delayed absorption properties. Urinary studies indicate that absorption is slow but complete.[5] Clinical studies[3] with mixed salicylic esters† have demonstrated its comparative freedom from gastric irritation and its prolonged analgesia, affording pain relief throughout the night and relief from the characteristic stiffness of arthritic joints on wakening.[3,4]

Sixty-six of the patients were on phenylbutazone at the start of the investigation. Initial dosage of phenylbutazone was 600 to 800 milligrams daily, but this was reduced to the minimum dosage which would maintain the pain relief for the individual. When mixed salicylic acid esters† were started (one tablet after meals and at bedtime—daily dosage 40 grains) the phenylbutazone daily dose was lowered by 10 to 20 per cent. This was reduced at one to three week intervals in patients who continued to maintain the same relief. If relief was not maintained, the prior

5. Hanzlek, J. and Presho, W.: Journal of Pharmacology and Experimental Therapeutics, 26:61 (January 1925).

dose of phenylbutazone was reinstituted. Mixed salicylic acid ester dosage was kept constant.

In thirty patients the salicylic esters† alone constituted initial therapy. If adequate relief was not obtained, phenylbutazone therapy was added to the regimen after one week. No attempt was made to obtain an improved result by increasing the dose of the salicylic esters.† All patients received four tablets (40 grains) daily throughout the study.

RESULTS

Clinical evaluation of the results in 66 arthritic patients after minimal maintenance dosage had been established is given in Table 2. Without sacrificing the improvement gained, it was possible entirely to discontinue phenylbutazone in 15 patients (23 per cent) and substantially reduce phenylbutazone maintenance dosage in 32 patients (48 per cent) when mixed salicylic acid esters† were given. In 19 patients (29 per cent) phenylbutazone had to be continued at the dosage level established. (Table 3). The overall intake of phenylbutazone in the entire group was reduced to approximately 60 per cent of the former total.

TABLE 2.

RESULTS WITH PHENYLBUTAZONE AND PHENYLBUTAZONE PLUS MIXED SALICYLIC ESTERS†

Type of Arthritis		Excellent	Good	Fair	Poor
Rheumatoid					
Mild	8	7	1	0	0
Moderate	9	8	1	0	0
Severe	6	2	3	1	0
Total	23	17	5	1	0
Osteo					
Mild	7	2	4	1	0
Moderate	12	2	6	3	1
Severe	9	1	3	2	3
Total	28	5	13	6	4
Mixed					
Mild	3	1	2	0	0
Moderate	7	1	6	0	0
Severe	5	1	2	1	1
Total	15	3	10	1	1
Grand Total	66	25	28	8	5
Per Cent	100	38	42	12	8

TABLE 3.

MIXED ESTERS OF SALICYLIC ACID AS PHENYLBUTAZONE REPLACEMENT

Type of Arthritis	Severity	Successful Completely Replaced	Successful Partly Replaced	Unsuccessful
Rheumatoid				
Mild	7	3	2	2
Moderate	9	3	4	2
Severe	7	1	3	3
Total	23	7	9	7
Osteo				
Mild	8	2	4	2
Moderate	13	4	7	2
Severe	7	0	4	3
Total	28	6	15	7
Mixed				
Mild	4	1	2	1
Moderate	6	1	3	2
Severe	5	0	3	2
Total	15	2	8	5
Grand Total	66	15	32	19
Per Cent	100	23	48	29

Thirty patients received the mixed salicylic acid esters as the initial therapy. One-fifth of these were maintained satisfactorily with no additional medication. The other 80 per cent needed varying amounts of phenylbutazone. More impressive clinical results were obtained earlier when the more potent drug was administered first. Table 4 exhibits results before phenylbutazone was added to the regime.

TABLE 4.

RESULTS OF INITIAL TREATMENT‡

WITH SALICYLIC ESTERS ALONE

Type of Arthritis		Excellent	Good	Fair	Poor
Rheumatoid					
Mild	2	0	1	1	0
Moderate	4	0	0	4	0
Severe	3	0	0	1	2
Total	9	0	1	6	2
Osteo					
Mild	2	0	1	1	0
Moderate	2	0	1	1	0
Severe	2	0	0	0	2
Total	6	0	2	2	2
Mixed					
Mild	2	0	1	0	1
Moderate	1	0	0	0	1
Severe	1	0	0	0	1
Total	4	0	1	0	3
Bursitis					
Mild	0	0	0	0	0
Moderate	0	0	0	0	0
Severe	5	0	0	0	5
Sacro-iliac					
Mild	2	0	1	1	0
Moderate	1	0	1	0	0
Severe	3	0	0	1	2
Total	6	0	2	2	2
Grand Total	30	0	6	10	14

‡After one week, phenylbutazone was given to the patients who showed a "Fair" or "Poor" response to the mixed salicylic acid esters alone.

TOXICITY

THE most *common* side effects produced by phenylbutazone are nausea and edema. The edema is caused by sodium retention. The most *serious* side effects of phenylbutazone (and other pyrazolones) are agranulocytosis, reactivation of latent peptic ulcer, exfoliative dermatitis, and thrombocytopenia.

The most *common* side effect caused by salicylates is gastric distress. Except among individuals allergic to salicylates, *serious* side effects ("salicylism") are produced only by overdosage. Doses under 75 grains daily (in patients of average weight and with normal renal function) rarely produce salicylism. First indications of overdosage are tinnitus and vertigo. If salicylate therapy is continued at the same dose, these warning signs may be followed by nausea, vomiting, hyperpnea and acidosis. A reduction in clotting time of the blood, gastro-intestinal bleeding, and a reduction in blood sugar in diabetics have been reported with dosage levels which may cause tinnitus.

Among our 96 patients there were *no serious side effects*. This is attributed to the reduction made in phenylbutazone maintenance dosage to minimal levels. This was made possible in most of the cases by concomitant use of mixed salicylic acid esters.† Excessive dosage has been associated with many of the toxic reactions reported with phenylbutazone. Maintenance dosage of 400 milligrams or more daily may cause cumulative toxic effects.

Minor side effects were comparatively few in number and in no case necessitated discontinuance of either therapy. Nausea and vomiting may be caused by either therapy. These symptoms occurred in five patients. None complained of the epigastric pain so often encountered with the soluble salicylates. Tinnitus, without vertigo, was reported by seven patients. Since the salicylate dosage prescribed was well below the level associated with the production of tinnitus, the possibility of concurrent self medication with aspirin suggested itself. Re-emphasis on omission of aspirin during drug therapy prevented recurrences. The headaches reported appear to have been coincidental. (Table 5).

Occult blood was found in a stool examination of three patients. In one patient this observation occurred twice. However, no overt sign of peptic ulceration occurred. An antacid

TABLE 5.

SIDE EFFECTS

	Patients	Nausea and/or Vomiting	Tinnitus	Vertigo	Headache	Gastric Pain	Occult Blood In Stool
First phenylbutazone; then plus mixed esters	66	4	3	0	4	0	3
First mixed esters; then plus phenylbutazone	30	1	4	0	2	0	0
Total	96	5	7	0	6	0	3

was given as a precautionary measure to these patients.

The fasting blood sugars of the six diabetic patients were slightly lower during therapy with the mixed esters. No other changes or abnormalities were revealed by the urinalyses or blood studies. No consistent effect on the sedimentation rate was noted.

In the treatment of the arthritic diseases, the clinician must be sure not to create new complications from serious drug side effects. At the same time he wants to afford his patients maximum relief from crippling pain.

A variety of new adrenal steroid compounds have been developed with the hope of satisfying these objectives. To date, steroid chemistry has not provided the wonder drug sought. The complications caused by the corticosteroids are particularly serious because of their insidious and obscure nature.

The clinical situations in the arthritic diseases in which the long-term use of the adrenal steroids appear justified are actually few if indications are carefully appraised prior to their use.

When phenylbutazone is given, precautions include periodic blood counts, regular weighing of the patient and alertness to agranulocytosis, gastric ulceration and thrombocytopenia. After initial therapy of 400 to 800 milligrams daily for 2 to 6 days, dosage should be reduced to the minimal level effective for the individual. If improvement is not obtained in the initial period, the drug should be discontinued.

The salicylates pose the least threat of harm and are the drugs of first choice. The usefulness of the salicylates is significantly enhanced by mixed salicylic acid esters† which provide a more sustained analgetic effect. The measure of relief provided by these esters cannot be predicted by the severity of the structural damage, pain, or limitation of function. In 22 per cent of the cases in the present series, the mixed salicylic acid esters† alone provided adequate therapy; and the possibility of serious side effects of the more potent drugs was altogether avoided. In most of the remaining patients, without sacrifice of clinical benefit, the risks posed with phenylbutazone were greatly reduced by the lowered phenylbutazone dosage which was made possible by concomitant salicylic ester therapy.

The reduced risk of serious side effects was accompanied by a low incidence of minor side effects.

SUMMARY AND CONCLUSIONS

1. A study was conducted to determine the analgetic value in arthritis of a tablet† containing salicylsalicylic acid 490 milligrams and acetylsalicylic acid 160 milligrams. The tablet was given four times a day to 96 patients: 32 cases of rheumatoid arthritis, 34 of osteoarthritis, 19 mixed arthritis (osteoarthritis superimposed on rheumatoid), 5 of recurrent bursitis and 6 of recurrent sacro-iliac pain.

2. The analgetic effect was well sustained on four tablets a day. As the initial and only medication it provided adequate relief in 20 per cent of the previously untreated patients. This tablet replaced phenylbutazone successfully in 23 per cent of the cases on that therapy and partly replaced phenylbutazone in 48 per cent.

3. Consumption of phenylbutazone was reduced to 60 per cent of the previous total.

4. With the reduced dosage of phenylbutazone, there was a corresponding decrease in risk of serious side effects. Not a single serious side effect developed in any of these 96 patients.

5. Minor side effects were not troublesome and were few in number. In no case was discontinuance of either therapy necessary.

6. Mixed salicylic acid esters† are effective in arthritis.

7. When resort to more potent drugs is necessary for control of pain, continuance of salicylic ester therapy lessens the dose required and the risks faced for most patients.

183 Broad Street

Hospital Charges

Charges for basic hospital services—room, board, routine nursing care and minor supplies—average from $15 to $20 a day in hospitals across the nation, the 1961 American Hospital Association survey has shown. Rates vary according to type of accommodation, hospital size, and ownership, and geographic area. More than half of all beds (54 per cent) are in accommodations within the range of $12 to $20 per day; an additional 27 per cent from $20 to $28. Fifteen per cent are below $12 and only 4 per cent are $28 or over.

This survey, *Daily Service Charges in Hospitals*, 1960, deals with figures obtained from 4,692 short-term nonfederal hospitals, 94 per cent of 5,455 such hospitals listed by the AHA. The hospitals have 543,758 beds.

The new survey provides a benchmark for comparisons of charges in future years, the report said. By comparison with previous years, a general increase in average charges was noted. This increase "reflects not only rising hospital costs but also a trend toward a more realistic balance between charges for routine daily services and unit charges for special services."

The survey showed:

Only 2 per cent of the 4,692 hospitals use inclusive rate systems with a single charge covering both routine daily services and special services. Three geographic areas (New York City, Cleveland and California) accounted for 60 per cent of these inclusive rate hospitals.

Average daily charges for all hospitals, according to accommodation, were as follows: single-bed, $20; two-bed, $17.50; four-bed, $15.80; and six or more-bed, $15.10.

The total beds in two-bed accommodations accounted for nearly 44 per cent of all beds in the surveyed hospitals, a far greater proportion than in any other category.

The proportion of beds in accommodations with six or more beds was sharply higher in the New England and Middle Atlantic regions, in hospitals of 500 beds or more, and in hospitals under state, city and county auspices.

Highest average charge for all accommodations was found in the Pacific region, with New England a close second; the lowest averages were in the West South Central states.

Among hospitals classified by number of beds, there was a steady and marked increase in average charges with increasing size of hospitals for three categories; single-bed, from $13 in hospitals of less than 25 beds to $24.50 in hospitals with 500 or more beds; two-bed, from $12.40 to $19.20, and four-bed, from $11.90 to $18.70.

Charles M. Lewis, M.D.

Paterson

The Pathophysiology of Constipation*

Television has made the American public more "regularity" conscious than ever before. Physicians should have enough understanding of the physiology and psychology of elimination to serve as good advisers on this subject.

Our understanding of the pathophysiology of constipation has progressed little since the turn of the century when Hurst [1] summarized the data available at that time, supporting it with much work of his own. Some aspects of his thesis are accepted today but improved methodology has altered many of the older concepts, and opened new areas for the study of colonic function. I would like to depart from the traditional classification of constipation and to approach the subject primarily in terms of altered physiology.

The process of elimination is a complex conditioned reflex depending for proper function on coordination of the various components. They will be considered under the following headings:

I. Innervation—Motility
   - A. Autonomic
   - B. Voluntary
   - C. Gastro-colic reflex

II. Muscular Contractility
   - A. Elasticity
   - B. Electrolytes
   - C. Other

III. Intestinal Contents
   - A. Dietary Composition
     1. Bulk
     2. Fluid
     3. Electrolytes
     4. Irritants

IV. Psychophysiologic Considerations
   - A. Spastic colon
   - B. Deconditioned colon
   - C. Imaginary constipation

MOTILITY

The propulsion of fecal material logically divides into two phases. The first is involuntary and involves the passage of contents from the cecum to the rectum. The stimulus is provided by the ingestion of food and the response consists of the so-called "mass movement" resulting from contraction of the right colon simultaneous with relaxation of the sigmoid, allowing the semi-solid material to be milked along by a succession of contractions. The chemical mediation of normal propulsion is cholinergic. This sequence is commonly known as the gastro-colic reflex.

The impulses are probably conveyed through the intrinsic plexuses with modulating effects supplied by the lumbar sympathetics which act as inhibitors and the parasympathetics which act as stimulators. The right colon receives parasympathetic fibers from the vagus and the left colon from the sacral segments.

Cholinergic impulses appear to have reciprocal effects on the right colon and sigmoid, the latter acting as a physiologic sphincter.

*Read May 19, 1960 at the Gastroenterology and Proctology Section of the 194th Annual Meeting of The Medical Society of New Jersey.

The intrinsic plexuses of Auerbach and Meissner appear to be the only indispensable links in the chain of neurologic control. Studies of embryonic guinea pigs reveal that the gut becomes capable of activity only after the development of these structures. Denervation of the colon both clinically as well as experimentally demonstrates that function is retained or very rapidly regained if the gut is intact.

The converse is shown clinically in Hirschprung's disease in which congenital absence of ganglion cells in a rectal segment results in obstipation secondary to a failure of impulse propagation. Resection of the diseased segment results in normal function.

Voluntary control begins with the second phase of motility. The conditioning process involved in bowel training results in the ability to modify the infantile defecation reflex. In the adult the presence of feces in the rectum is consciously perceived. The fecal mass causes reflex tonic contractions of the external sphincter which is under voluntary control. This reflex may be overcome by effort in the process of defecation. Painful lesions of the anus may cause sphincter spasm or reluctance to defecate, resulting in the form of constipation seen commonly by proctologists.

MUSCULAR CONTRACTILITY

THE properties of colonic muscle have never been adequately investigated in the human. Suspected for years has been constipation due to smooth muscle failure, the so-called atonic constipation. Absolute proof of this phenomenon has remained elusive. Similarly, the constipation of hypothyroidism may be due to defective muscular contractility. Recently Lipkin and Almy[2] have succeeded in measuring the elasticity of the bowel. By means of a balloon in the sigmoid colon, a measured volume of water is instilled. Simultaneous measurements of pressure are automatically integrated and shown on the screen of the oscilloscope from which it is recorded on film. From these measurements, the coefficient of elasticity is mathematically derived. By this means the influence of drugs as well as disease states on elastic properties of the colon have been studied. This method promises to throw much light on an obscure subject.

The suspected relationship of hypercalcemia to the constipation of hyperparathyroidism and the demonstration of hypokalemia in ileus suggests that the role of electrolytes in muscular function could profitably be investigated. As yet, there is little information on this subject.

INTESTINAL CONTENTS

STOOL bulk is necessary for elimination but it is unlikely that lack of dietary bulk alone is a cause of constipation. Fecal residue is composed of bacteria, mucosal debris, enzymes, water and electrolytes in addition to undigested food. The contribution of intestinal epithelium is considerable. Studies using radioactive labeled amino acids indicate that the mucosal cells of the gut are completely regenerated in about 48 hours. The volume of waste material produced in this process theoretically provides considerable bulk for defecation. This is demonstrated in fasting individuals who continue to form stools of roughly normal composition. It is likely that the constipation which these patients experience is due to failure to initiate the gastro-colic reflex.

The residue of undigested food consisting of fiber and cellulose may act in another way to stimulate defecation. The action of bacteria liberates a number of irritating substances including indole, skatol, organic acids and oils. It has been suggested that they play a role in normal intestinal motility, particularly in view of the close chemical relationship to the pharmacologically active serotonin. Bacteria have a "digestive" function, but they also contribute to intestinal bulk, though probably to a lesser degree. Animals reared for several generations in a germ-free environment have no difficulty with defecation.

The importance of dietary water to stool consistency has been overemphasized in the normally hydrated individual. The small bowel

has no threshold for water absorption. Excess water intake is excreted by the kidney. On the other hand, osmotically active substances do retain water in the gut. In the normal state, however, the consistency of the stool is more closely related to the speed of colon transport, than to dietary water.

PSYCHOPHYSIOLOGIC FACTORS

THE influence of emotions on bodily function has been known for many years. Early observers noted a relationship between constipation and depression. These observations were amplified and extended by White and his co-workers.[3] Later investigators[4] using psychoanalytic technics attempted to explain the subconscious meaning of constipation in analytic terms.

Recently, Almy and co-workers,[5] using the stress interview simultaneously with sigmoidoscopic observation of sigmoid engorgement and contraction, noted spasm and hyperemia in response to physical pain or emotionally disturbing conversation. The same relationship was also studied by means of pressure tracings of colonic motility. In these experiments, the same stimuli resulted in accentuated contractions thought to represent sigmoid spasm. This was shown in healthy medical students as well as in patients suffering from spastic colon. It was concluded that this reaction was a physiologic accompaniment of the organism's total response to threatening situations. By a subtle transfer, emotional stimuli replaced the physical ones and produced responses normally meant for the primitive purpose of fight or flight of which stool retention is an essential part.

The accompanying emotional feelings were those of tension, hostility, defensiveness and tenacity; attitudes commonly observed clinically in patients having spastic constipation. These experiments point out that individuals with organically normal bowel structure who would be classified as emotionally normal by most methods are equally susceptible to spastic constipation though their threshold may be higher than regular sufferers.

The second variety of functional constipation is sometimes called "dyschesia." I prefer to call it the "deconditioned colon" to indicate that there are more than just rectal factors involved. Indeed, anything which interrupts the normal pattern of defecation may produce this condition. Small irregular meals which fail to stimulate the gastro-colic reflex are common causes; so are missed breakfasts and other dieting fads, and suppression of the urge to defecate because of inappropriate time and place; any of these situations may cause a gradual diminishing of the defecation urge. Evacuation may occur at irregular times and is usually incomplete, leaving a full rectum. A disturbance of the general state of well-being may result to a greater or lesser degree, depending on the individual. Proctologic causes often produce this variety of constipation. Similarly, the constipation of psychosis and organic mental syndromes fall in this group.

In the last category I include "imaginary constipation" comprised, for the most part, of people with misconceptions of the meaning of "regularity." Most are convinced that without one movement a day they are doomed to a life of invalidism if not death. Many are satisfied only with three or more movements a day to be certain "that each meal is eliminated." These patients must learn that "regularity" can be judged only in the light of an individual's past pattern. There is no universally normal pattern. It is not unusual for an individual to have only one movement a week, and cases of one movement every two weeks or one a month are on record in perfectly normal individuals. One must be careful in dealing with patients in this group to be alert for the occasional masked psychotic whose complaint of constipation may actually represent a delusion.

A review of the physiology of elimination should clarify its pathophysiology. This approach provides the foundation upon which a solid therapeutic structure may be built.

600 Broadway

Bibliography will appear in author's reprints.

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Trichlormethiazide in the Management of Congestive Heart Failure

Trichlormethiazide was found to be an effective diuretic in congestive heart failure in this study of the new drug in 35 patients.

The renal changes secondary to impaired myocardial function decrease the body's ability to rid itself of excessive sodium and water. Fluid retention is a significant component of the congestive heart failure syndrome and must be treated vigorously. Until recently, however, none of the available diuretics was free from at least one major disadvantage. The organic mercurials are excellent diuretics when given parenterally; but they are poorly absorbed after oral administration. The carbonic anhydrase inhibitors are effective orally but disturb the acid-base balance and cause potassium loss; also, refractoriness after relatively brief therapy is common.

A major advance in diuretic therapy was the introduction of the benzothiadiazine diuretics. These agents (particularly the newer improved analogues) unquestionably add years of reasonably normal activity to the lives of thousands of patients with heart disease.[1] They are nontoxic and tolerance does not develop. The benzothiadiazine diuretics thus, are suitable for chronic as well as brief or intermittent therapy.[2] Dosage can be precisely adjusted to meet changing requirements. It is now possible to keep most patients with congestive heart failure well controlled for long periods of time.[3]

The site of action of the benzothiadiazine diuretics probably is the proximal renal tubule, where they inhibit resorption of sodium.[3,4,5] The renal plasma flow and glomerular filtration rate are not affected.[6] We have had good results with these agents and previously reported our experience with chlorothiazide (Diuril®)[7] and benzydroflumethiazide (Naturetin®).[8]

A new benzothiadiazine diuretic, trichlormethiazide (Naqua®)[9] was introduced recently. The milligram potency, as compared to chlorothiazide, was increased by a factor of approximately one hundred; more important, proportionately lessened potassium excretion provides a more favorable ratio of electrolyte activity.[6] The effect of seven diuretics, including the benzothiadiazines, was compared in

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animals by Rennick,[5] who reported that trichlormethiazide was highest in naturetic potency but very low in carbonic anhydrase activity. This relationship held true for the other benzothiadiazines: on a milligram-for-milligram basis, the degree of carbonic anhydrase activity proved to be inversely proportional to the naturetic potency.

According to Ford,[10] the significant points of the trichlormethiazide dose-response-curve in humans occurred between 4 and 8 milligrams daily. At 16 milligrams daily there was no evidence of tolerance or toxicity. The serum electrolyte values remained within normal limits. The diuretic slightly increased excretion of potassium and bicarbonate over pretreatment values but the changes were of lesser magnitude than those following administration of chlorothiazide or hydrochlorothiazide (Hydrodiuril®). Excretion of sodium and water continued until all excess stores were lost but the increase in potassium excretion did not continue beyond the first few days of administration.[10]

Using weight loss as the index of diuretic activity, Hutcheon and Takasu[4] studied the effects of trichlormethiazide in nine patients with congestive heart failure. Hydrochlorothiazide and a placebo were used as controls in a cross-over design. Optimal daily dose range for mobilization of edema fluid was between 4 and 16 milligrams. After one week of treatment with trichlormethiazide, the serum electrolytes, serum creatinine, and pH values in these patients were within normal limits. A slight but not significant decrease in serum potassium was noted after one week of therapy with 16 milligrams trichlormethiazide or 75 milligrams hydrochlorothiazide daily. On a milligram-for-milligram basis, the naturetic potency of trichlormethiazide was ten times that of hydrochlorothiazide and, by analogy, one hundred times that of chlorothiazide.

Among 67 patients treated with trichlormethiazide by Ernst,[11] 55 had congestive heart failure. There was excellent diuresis as indicated by weight loss and diminution of cardiac symptoms. Fewer patients required supplementary potassium with trichlormethiazide than with chlorothiazide or hydrochlorothiazide.

The purpose of this study was to determine the efficiency of trichlormethiazide as a diuretic in congestive heart failure, particularly in comparison with other agents in its class. Our series was composed chiefly of patients who were responding well to other benzothiadiazine diuretics. We administered trichlormethiazide in doses approximately equipotent to whatever diuretic had been used before this trial.

METHODS

Congestive heart failure was the indication for diuretic therapy in 35 patients and cirrhotic anasarca was the indication in one patient. Primary diagnoses among the patients with congestive failure were arteriosclerotic heart disease (29 patients); rheumatic heart disease (two); hypertensive heart disease, *cor pulmonale*, congenital septal defect, and heart disease of unknown etiology (one each). In addition, 26 of these patients had enlarged hearts; 14 had histories of myocardial infarction; nine had auricular fibrillation; three had pulmonary edema or emphysema; two had the anginal syndrome, and two had mitral insufficiency. Ages of these 22 males and 14 females ranged between 41 and 83 years; the mean age was 66.

All but five of the patients had received other diuretics for periods of from two months to seven years before the trial with trichlormethiazide.* One had received 500 milligrams acetazolamide (Diamox®); six had received 500 milligrams chlorothiazide; seven had received 25, 50, or 100 milligrams hydrochlorothiazide; and 17 had received 2.5, 5, 10, or 20 milligrams benzydroflumethiazide. Concomitant therapy consisted of digitalis, low-salt diet, and reserpine if there was associated hypertension. These

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11. Ernst, E. M.: Pennsylvania Medical Journal, 63:1629 (1960).

*Trichlormethiazide (Naqua®) was provided for this trial by R. Richard McCormick, M.D., Medical Research Division, Schering Corporation, Bloomfield, N. J.

measures were continued when trichlormethiazide was substituted for the previous diuretic.

Trichlormethiazide was given for five consecutive days each week and discontinued on weekends. Dosage was 4 milligrams daily except for three patients who received 2 milligrams daily, one patient who received 8 milligrams daily, and two who received 16 milligrams daily. These were approximately equipotent to the doses of previously used drugs. Previously untreated patients were started on 4 milligrams daily; this was later increased for one patient. Patients were seen at frequent intervals for periods of observation ranging between six weeks and six months.

RESULTS

THE effect of trichlormethiazide was demonstrated most clearly in those patients who had not been treated previously. Their case histories are summarized in the Table. The drug was effective in relieving edema and the respiratory symptoms associated with fluid retention in the chest cavity. These patients were substantially symptom-free during the period of therapy. All patients lost weight (5 to 15 pounds) as a consequence of diuresis and two, who were moderately hypertensive at the start of therapy, showed reduction of the blood pressure of 30 and 20 millimeters (systolic). The cardiac symptoms responded to digitalis.

Clinical judgments about the other patients were based on changes in the symptoms and signs of congestive failure as listed in the Table. These factors were correlated to estimate if the patient had improved, worsened, or remained substantially unchanged when trichlormethiazide was substituted for whatever diuretic had been used previously. Of these 31 patients, 21 maintained the previous clinical status, eight were improved as compared to the status with previous diuretics, and two

RESULTS IN PREVIOUSLY UNTREATED PATIENTS

	Case 1	Case 2	Case 3	Case 4	Case 5
Diagnosis*	A,C,E	A,B,C,M	A,C	A,C,E,M	A,C,P
Age and sex	71M	63M	67M	72M	68M
Duration of Treatment	2 months	3 months	3 months	4 months	6 weeks
Daily dosage	4 mg.	4 mg.	4 mg.	16 mg.	4 mg.
Other medication	Digitalis, KCl	Digitalis	Digitalis	Digitalis	Digitalis
Side effects	Weakness	None	None	None	None
Blood chemistry (after)	BUN 25 mg.	Normal	Normal	Normal	Normal

Symptoms and Signs Before (First column) and After (Second column) Therapy

Insomnia	+	—	+	—	—	—	+	+	+	—
Dyspnea	+	—	+	—	—	—	+	—	+	—
Orthopnea	+	—	+	—	—	—	+	—	+	—
Cough	+	—	+	—	—	—	—	—	+	—
Paroxysmal dyspnea	+	—	++	—	—	—	—	—	+	—
Edema	+	—	+	—	—	—	+	—	+	—
Weight	138	129½	154	146	206	200	186	171	152	147
Blood pressure	120/80	126/70	130/76	120/76	160/86	130/80	110/60	110/60	160/80	140/66
Heart rate	120	88	96	80	72	64	88	72	75	72
Heart rhythm**	ST	RSR	RSR	RSR	AF	AF	RSR	RSR	RSR	RSR
Gallop rhythm	+	—	—	—	—	—	+	—	+	—
Rales	+	—	+	—	—	—	+	—	+	—
Effusion	—	—	—	—	—	—	—	—	—	—
Neck veins distention	+	—	+	—	—	—	+	—	+	—
Hepatojugular reflux	+	—	+	—	+	+	+	—	+	—
Hepatic enlargement	++++	—	++	—	++	++	++	+	+	—

*A—arteriosclerotic heart disease
B—anginal syndrome
C—congestive failure
E—enlarged heart
M—previous myocardial infarction
P—pulmonary edema

**ST—sinus tachycardia
RSR—regular sinus rhythm
AF—auricular fibrillation

apparently worsened. Both of these latter patients (one of whom also had diabetes mellitus) initially responded well to trichlormethiazide but later weight gain and recurrence of edema indicated clinical regression.

The patient with cirrhosis gained six pounds and showed some worsening of his condition during the first month of treatment with trichlormethiazide; however, there was no further regression during the following month and therapy was considered satisfactory.

Most patients did not have hypertension at the start of treatment with trichlormethiazide. The blood pressure usually remained within normal limits or decreased slightly. The exceptions were eight moderately hypertensive patients (including two previously untreated) whose blood pressure was *reduced* 20 millimeters or more (systolic or diastolic or both) and four patients whose pressure *increased* 20 millimeters or more. Trichlormethiazide never depressed blood pressure below normal limits and there was no clinical evidence of hypertension.

Most patients lost weight and ten patients (including the five previously untreated) lost five pounds or more; two gained five pounds or more.

Serum electrolyte values were determined after treatment with trichlormethiazide. Values for sodium ranged between 138 and 145 mEq. per liter, for potassium between 3.7 and 4.7 mEq. per liter, and for chloride between 98 and 107 mEq. per liter. These ranges are within normal limits. The pH of the blood was normal in all patients and the blood urea nitrogen was normal in all but two patients who had values of 25 and 35 milligrams per 100 cubic centimeters.

One patient, who had received 2 milligrams trichlormethiazide daily, developed gout of one hallux; the blood uric acid was 4.5 milligrams per 100 cubic centimeters. Phenylbutazone (Butazolidin®) was administered and the symptoms cleared within three days.

Four patients (two of whom also had multiple premature ventricular contractions) complained of weakness suggestive of hypokalemia and were therefore given three grams of potassium chloride daily. However, there was no abnormality of the serum electrolytes. The dosage of trichlormethiazide for these four patients did not exceed four milligrams daily; they also received digitalis.

The equipotency of trichlormethiazide to other agents in its class was estimated on the basis of clinical response. The standard daily dose of four milligrams was equipotent to 250 milligrams acetazolamide (one patient); 500 milligrams chlorothiazide (six patients); 50 milligrams hydrochlorothiazide (four patients) or 100 milligrams hydrochlorothiazide (three patients); 5 milligrams benzydroflumethiazide (15 patients) or 10 milligrams benzydroflumethiazide (two patients).

DISCUSSION

THE clinical course of patients with cardiac disease, and in congestive heart failure, fluctuates so widely that evaluation of the effect of therapy is beset with many problems. It is difficult to know if an apparent decline reflects failure of the drug or the natural history of the disease. We agree with the conclusion of Fuchs and colleagues[6] that ". . . poor response to the drug due to progression of the disease process or change in the dynamics or severity of the physiopathology may be miscontrued as tolerance."

Weakness is not necessarily associated with subnormal serum potassium values, and therefore the possibility that it is not caused by hypokalemia should be considered. Patients feeling relatively well may increase their activity beyond a desirable point and the weakness results from fatigue rather than from electrolyte imbalance. If more than one drug is given to patients, it is often difficult to decide which drug, if any, is responsible for reported side effects.

Electrolyte disturbances usually attributed to administration of the diuretic may, in patients with severe congestive heart failure, actually be manifestations of the disease.[1]

In our series, the patients who received the

relatively high doses of trichlormethiazide had failed to respond to standard doses of other diuretics. Many patients who do not respond sufficiently to the usual therapeutic dosage of a diuretic can tolerate the higher doses which will be effective. Hypokalemia has not been a problem with trichlormethiazide, but patients who receive relatively high doses of any diuretic should be placed on a diet rich in potassium and should also receive potassium chloride, 3 Grams daily, prophylactically. This is especially important[3] if, as is usually the case, digitalis is being given concomitantly.[2] It is often desirable to administer the diuretic for only five days each week.[1]

One of our patients had a mild, brief attack of gout during therapy with trichlormethiazide and this might have been provoked by the drug. Gout has been reported[3] with other benzothiadiazine diuretics but is not usually a problem except in patients already susceptible to the disease.[12] Discontinuance of the diuretic and administration of a drug such as phenylbutazone usually clears the attack.

It is possible for a benzothiadiazine diuretic to elevate the level of blood urea nitrogen;[2] however, the elevated blood urea nitrogen level observed in two of our patients was, according to the histories, clearly a consequence of cardiorenal disease and only coincidentally related to administration of trichlormethiazide.

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CONCLUSION

TRICHLORMETHIAZIDE is an effective diuretic agent free from significant side effects. Some patients will respond better to one rather than another diuretic and therefore it is important that the physician have several diuretics from which to choose.

SUMMARY

1. Trichlormethiazide (Naqua®) was administered to 35 patients with congestive heart failure and one with cirrhotic anasarca. Usually 4 milligrams daily were given for five days of each week; the total period of therapy ranged between six weeks and six months. All but five patients had been treated previously with other diuretics, usually benzothiadiazines.

2. Some patients showed distinct improvement when trichlormethiazide was substituted for the diuretic used previously; and most of the other patients responded as well to trichlormethiazide as to any other benzothiadiazine. The previously untreated patients all had an excellent diuretic response. The usual signs and symptoms of congestive failure disappeared or were substantially reduced. Serum electrolytes remained within normal limits. An attack of gout, in one patient, might have been a side effect of the drug.

299 Clinton Avenue

Improved Preservation of Frozen Tissue

A method of preserving frozen human and bovine blood cells has been described. Dimethyl sulfoxide gives more effective protection against the damaging freezing-thawing process than several other compounds, report J. E. Lovelock and M. W. H. Bishop of the National Institute for Medical Research, London (Nature, May 16, 1959). Glycerol and other natural solutes prevent freezing damage to living cells.

Dimethyl sulfoxide penetrates the red blood cell more quickly, and less is needed for complete protection against freezing. Two hours in glycerol before freezing gave poor protection to both bovine and human red blood cells. However, only thirty seconds in dimethyl sulfoxide gave complete protection.

Daniel Boyle, M.D.

Joseph M. Tobin, M.D.

Princeton

Pharmaceutical Management of Behavior Disorders*

Chlordiazepoxide in Covert and Overt Expressions of Aggression

If patients with aggressive, chronic behavior disorders are treated with chlordiazepoxide, there is a 50-50 chance of substantial improvement, according to the study from our State's Bureau of Research in Neurology and Psychiatry.

The prime purpose of this study was to evaluate the effectiveness of chlordiazepoxide† in hospitalized patients whose symptom profile included behavioral disorders such as hyperactivity, aggressiveness, motor agitation, hostility, assaultiveness and similar manifestations. The rationale for this approach was the taming effect of chlordiazepoxide on animals reported by Randall[1], Randall, *et al.*[2] and by Heise and Boff,[3] as well as our observation that patients with anxiety and tension states showed definite improvement in these behavioral disorders when they were treated with this drug.

METHOD OF STUDY

The series consisted of 25 patients in residence at the New Jersey Neuro-Psychiatric Institute. Eight were male.

Ages of the males ranged from 13 to 41 years (median age 25 years) and duration of their illness from 9 to 41 years (median duration 24 years). This group included 5 patients with chronic brain syndrome; 2 with schizophrenic reaction, childhood type; and one with idiopathic mental deficiency of moderate degree. In addition, 4 of the 5 patients with chronic brain syndrome were mentally deficient, three had a psychotic reaction and four a past history of convulsive disorders. In the male group the following behavioral problems occurred, singly or in combinations: aggressiveness, assaultiveness, hostility and hyperactivity in three patients each; agitation and self-destructiveness in two patients each; and irritability, negativism, uncooperativeness and withdrawal in one patient each. One of the males showed signs of depression.

The age of the females ranged from five to 70 years (median age 36 years) and the duration of their illness from four to 58 years (median duration 27 years). This group included eight patients with chronic brain syndrome; four with schizophrenic reaction, paranoid type;

*From the Bureau of Research in Neurology and Psychiatry, Princeton, Department of Institutions and Agencies.

†Marketed by Hoffmann-La Roche Inc., under the trade-name of Librium®.

1. Randall, L. O.: Diseases of the Nervous System, 21:7 (January 1960).

2. Randall, L. O. *et al.*: Journal of Pharmacologic and Experimental Therapy, 129:163 (February 1960).

3. Heise, G. A. and Boff, E.: Federal Proceedings, 20:393 (January 1961).

two with schizophrenic reaction, hebephrenic type and one patient each with schizophrenic reaction, childhood type; schizophrenic reaction, chronic undifferentiated type and personality disorder, passive aggresive type. In addition, six of the eight patients with chronic brain syndrome were mentally deficient, two had a psychotic reaction and six a past history of convulsive disorders. In the female group the following behavioral problems occurred, singly or in combination: hyperactivity in 10 patients; aggressiveness in six patients; agitation in five patients; hostility in three; destructiveness in two; and "acting-out behavior," negativism and noisiness in one patient each. Four of the females showed signs of depression. One woman each had delusions of grandeur, persecutory delusions and hallucinations.

Not one of the 25 patients had significant response to various forms of sedative and ataractic medications. Five patients received electroshock therapy for sedation at initiation of this study and chlordiazepoxide† was added to this therapeutic measure

The dosage schedule of chlordiazepoxide was flexible and depended on the response. The daily dose of the drug ranged from 10 to 500 milligrams, but was 50 or 75 milligrams in the majority of patients. Duration of treatment varied from four days to over 10 months, with 11 patients continuing on treatment as of this date. In the one patient who received chlordiazepoxide for only four days, medication was discontinued because it seemed to increase his aggressiveness. Drug administration was maintained for a month or longer in 20 cases.

Hemograms and urinalyses were done at suitable intervals on all patients.

Clinical evaluation was based upon the change of the behavior pattern. Improvement was rated as marked, moderate, slight or "no change." Improvement was considered "marked" if there was complete amelioration of symptoms; as "moderate" if there was significant and sustained alleviation of symptoms; as "slight" if there was a noticeable and sustained reduction in the most severe symptoms. Results were classified as "no change" if the behavioral pattern was not (or only temporarily) improved. Evaluations were based on observations by ward personnel and on interviews by the consulting psychiatrists.

RESULTS

Of the eight males, one showed "marked" and two patients "moderate" improvement. Five were considered to show "no change" although three of them exhibited some initial improvement.

Of the 17 female patients, seven showed "marked," three "moderate" and two "slight" improvement. Two of the markedly improved women are being considered for discharge. Three other patients in this response group, and one with "moderate" improvement, who initially were given electroshock in conjunction with chlordiazepoxide,† maintained their degrees of improvement after discontinuation of the shock when they received chlordiazepoxide† alone. Five cases were considered to show "no change" although one of them had a transient remission of her agitation. However this was not sustained.

As appears from these data, the administration of chlordiazepoxide† produced some degree of improvement in the behavior pattern of 15 patients, or in 60 per cent of the series.

Side effects attributable to the administration of chlordiazepoxide were not observed nor did significant changes in the hemograms and urinalyses occur.

By diagnostic categories the improvement rates in the behavior pattern were as follows:

Chronic brain syndrome: Of the five males with this diagnosis, one showed *marked* and one *moderate* improvement. In three patients there was *no change*. Of the eight females in this category, two each showed *marked* and *moderate* improvement; but in four patients there was no change. Overall improvement rate in the behavior pattern for patients with chronic brain syndrome was 46 per cent.

Schizophrenic reaction: The two males with this diagnosis failed to improve. Of the eight

females in this category, four showed *marked*, one *moderate*, and two *slight* improvement. In one patient there was no change. Thus, 70 per cent of the patients in this diagnostic group showed some degree of improvement in their behavior pattern.

Of the remaining two patients, the one with a diagnosis of personality disorder, passive aggressive type, showed *marked* improvement, and the other with a diagnosis of mental deficiency, moderate with behavioral reaction, showed *moderate* improvement.

COMMENT

IN EVALUATING the effectiveness of chlordiazepoxide† in the management of behavioral disorders, it is necessary to consider the nature of the study series. These patients presented chronic, serious problems in management. In all instances, there was a long history of periodically or continuously disturbed behavior. Although the etiologic processes varied from chronic brain damage to chronic schizophrenic reaction, the clinical behavioral profiles were similar. Each patient served as his own control in the sense that the severity and protracted course of his symptoms as well as their refractoriness to other forms of treatment were well known.

An improvement rate of 60 per cent in this series is considered sufficient indication for the use of chlordiazepoxide† in the symptomatic management of behavioral disorders characterized by a direct or covert expression of aggression. It should be noted, however, that other symptoms such as delusions and hallucinations were not attenuated concurrently with the improvement in behavior. In this series we did not observe paradoxical rage reactions which occasionally occurred[4] in psychoneurotic and pseudoneurotic schizophrenic patients with a high level of directly perceived anxiety who were treated with chlordiazepoxide. It is concluded that chlordiazepoxide† is effective, in the majority of cases, in combatting behavioral disorders such as hyperactivity, aggressiveness, agitation, hostility, assaultiveness and similar manifestations, regardless of the underlying pathology.

SUMMARY

1. Twenty-five patients, eight males and 17 females were treated with chlordiazepoxide† for periods which ranged from four days to over 10 months. All patients presented behavioral problems including one or more of the following symptoms: hyperactivity, aggressiveness, agitation, hostility, assaultiveness, destructiveness and negativism.

2. The diagnostic categories included 13 patients with chronic brain syndrome, 10 patients with schizophrenic reaction, and one patient each with a personality disorder and mental deficiency with a behavioral reaction. Ten of the patients with chronic brain syndrome had a past history of convulsive disorders. Duration of illness of the patients in the entire series ranged from four to 58 years.

3. In terms of change in the symptom profile under study (behavioral problems) 15 patients, or 60 per cent, showed some degree of improvement. Of these, eight cases were markedly, five were moderately, and two slightly improved.

4. These results suggest that chlordiazepoxide† is a valuable agent in the treatment of chronic, severe behavioral reactions.

Thanks are expressed to Mrs. Adele Adlerstein who helpfully recorded and tabulated the data.

4. Tobin, J. M. and Lewis, N. D. C.: Journal of the American Medical Association, 174:1242 (September 1960).

Box 1000, Princeton

Board of Trustees

At its May 12, 1961 session, the Board of Trustees took a variety of actions which included the following:

Noted a request from Dr. Forte, our liaison representative with the Seton Hall Chapter of the Student AMA for a $150 donation to defray part of the expenses of a delegate to the Student Medical Association convention in Chicago on May 4, 1961. At its March 19 meeting, the Board received the recommendation. However, Dr. Donnelly, through a letter to the President, dated April 19, and in person, urge the Board to reconsider its action and to donate $100 toward the expenses of the delegate.

Action: The Board rescinded its action of March 19, 1961, which received and noted the request for the contribution. The Board then authorized an appropriation of $100 to help defray expenses incurred in sending a representative of the Seton Hall Chapter of the Student AMA to the convention in Chicago.

Dr. Featherston reported on the progress of our professional liability insurance program.

SOCIETY FOR MEDICAL RESEARCH

Consideration was given to an invitation for The Medical Society of New Jersey to accept membership in the National Society for Medical Research, an organization active in medical research and in protecting such research against the legislative attacks of anti-vivisectionists.

Action: The Medical Society of New Jersey will accept membership in the NSMR and make a contribution in the amount of $25.

MAY 16 MEETING

CHAIRMAN, 1961-62

Upon motion by Dr. Wegryn, Dr. Mulligan was nominated for re-election as chairman of the Board for 1961-62. There being no further nominations, Dr. Mulligan was unanimously elected.

SECRETARY, 1961-62

Upon motion by Dr. Greifinger, Dr. Kaufman was re-elected secretary of the Board for 1961-62.

COMMITTEE ON FINANCE AND BUDGET

The chairman reported that Dr. Ware's term, as a Trustee-member of the Committee on Finance and Budget, would expire at the close of the annual meeting.

Upon motion Dr. Ware was unanimously re-elected to membership on the Committee on Finance and Budget for a three-year term, 1961-64.

1961 AMA ANNUAL MEETING

The following Officers were authorized to attend the June 1961 meeting in New York City with expenses paid: President, President-Elect, Secretary, and Executive Officer.

Dr. Jehl and Dr. Bowers, as alternate delegates, were authorized to attend the 1961 AMA Annual Meeting with expenses paid.

REAPPOINTMENT OF SALARIED PERSONNEL

Upon motion by Dr. Collins—seconded by Dr. Bedrick, and carried—the salaried personnel, excluding those under individual contractual agreement, were reappointed for 1961-62 at the salaries set forth in the new budget.

BOARD MEETING SCHEDULE

The Board agreed that it would continue to meet regularly on the third Sunday of every month, meetings subject to cancellation when business for consideration proves insufficient.

SCHOOL HEALTH CONFERENCE

The Board received an announcement of a joint meeting of the American School Health

Association and the American Medical Association in New York on June 25. This will be a forum on school health problems.

Action: The chairman of our special committee on child health is authorized to attend this meeting, all expenses paid, as the representative of The Medical Society of New Jersey.

Morris County Student Loan Fund

The Morris County Medical Society has announced a medical student loan fund. In view of the desirability for increasing the number of physicians and the growing cost of medical education, the Society felt that it could aid needy students in pursuit of their medical training. The plan was conceived by Dr. Henry O. von Deilen, Morristown, and proposed to the Society by Dr. F. Clyde Bowers, Mendham, past-president of The Medical Society of New Jersey. A similar plan for student loans had been instituted last year by the State Society. A committee appointed by Dr. David P. Williams, past-president of the Morris County Medical Society, has drawn up the following salient requirements:

1. The fund shall be available to medical students who have satisfactorily completed the first two years in an approved medical school of the United States or Canada. The applicant must have been a resident of Morris County for at least five years prior to matriculation in medical school.

2. The candidate must be of good moral character, of acceptable academic standing and able to prove financial need.

3. Loans up to $1,000 annually will be available. Repayments are to begin two years after commencing practice or seven years after leaving school. Repayments are to be completed in five years thereafter at an interest rate of 3 per cent on the unpaid balance.

4. Each loan is to be secured by a note. Term life insurance payable to the Medical Society will be required of each borrower to cover the amount.

5. A personal interview is necessary for each applicant who is also required to obtain letters of reference from two members of the Morris County Medical Society and one from the Dean of his school.

6. All applications must be on file prior to April 1st of the appropriate year. Applications should be addressed to the Special Committee on the Student Loan Fund, Morris County Medical Society, 100 Madison Avenue, Morristown, N. J.

Financial Position of S.R.W.O.M.M.

The Society for the Relief of Widows and Orphans of Medical Men of New Jersey started the fiscal year on May 1, 1961 with $10,570 on hand and collected $13,626 during the year. Total expenses of running the Society for the year amounted to $846 and $11,330 was paid to widows of medical men who died during the year. In addition $1940 was transferred to the permanent fund for investment. The Permanent Fund has investments of $128,950 in bonds, preferred and common stocks as well as $7271 in cash on hand. This represents an increase this year of about $19,000. Earnings from this fund, amounting to $4,278.50, are used to help needy widows of former members. The officers and trustees are gratified with the financial condition of the Society, with the large increase in new members this year and are looking forward to increased activity this next year.

The retirement of Dr. Earl LeRoy Wood as president is a distinct loss to the Society which he has led for a number of years. Recognition of his retirement by suitable resolutions commending his "loyal, constructive leadership and his constant efforts to strengthen the Society" were suitably spread upon the minutes of the annual meeting.

Honor for Dr. Read

President Mason W. Gross conferred the Honorary Degree of Doctor of Science on Dr. Hilton S. Read, M.D., Director of the Ventnor Diagnostic Center and founder of the Ventnor Foundation at the Commencement of Rutgers University on June 7, 1961 with the following citation:

Hilton Shreve Read, distinguished practitioner and educator in the field of medicine, as a practicing physician you have gained widespread admiration; as a leader in medical education, you have received international acclaim. By your inspiration the Ventnor Foundation was established, and under your direction medical education, and, at the same time, international understanding have advanced.

In gratitude and respect, I am pleased to confer upon you, at the direction of the Board of Governors of the University *honoris causa*, the Degree of Doctor of Science.

In Defense of Brand Names

The following is abstracted from a talk by Dr. Theodore Klumpp to the Massachusetts Medical Society on May 24, 1961. Dr. Klumpp is a member of the "corporation" of the Peter Bent Brigham Hospital, and was chairman of the Hoover Commission's Task Force on Medical Services. Dr. Klumpp is now President of Winthrop Laboratories. The JOURNAL *publishes this as a matter of interest to our readers.*

Passage of legislation requiring pharmaceuticals to be sold under generic names would place public health in jeopardy and, at the same time, stifle the huge research programs financed by manufacturers of brand-name drugs, the Massachusetts Medical Society was told by Dr. Theodore G. Klumpp. If Congress were to enact such a law it would, he said, be a "powerful thrust" in socializing health services in the United States. All drugs containing the same active ingredients are not identical, the Massachusetts Society was told. Noting that much more goes into a drug than the active ingredients, Dr. Klumpp said:

Drugs having the same active ingredients and subject to the same standards may vary in more than 24 different respects and still be entitled to share the same generic name. These variations may make a decisive difference in the action of the drug.

When human life is at stake, the strength, purity and quality of a drug was termed a matter of critical importance.

"A recent survey of two drugs marketed by many firms disclosed that 35 per cent of the drugs sold under generic names were *below their officially prescribed standards*, whereas all those sold under a brand name were equal to or better than the designated minimum standards," Dr. Klumpp stated. "The Food and Drug Administration has testified that it is so inadequately staffed that its inspectors can visit each drug manufacturing establishment only once every five years.

"Even if the Food and Drug Administration had a staff as large as the Department of Defense it still could not inspect or test every batch of every food, drug or cosmetic manufactured. Which means that the only real assurance of strength, quality and purity of drugs is the integrity of the manufacturer.

"Those manufacturers who have confidence in their products give them brand names. No law can give you a better basis for confidence in the drug products you purchase."

The substitution of generic names for brand names would have the additional effect of discouraging investment in scientific research.

"Indeed, little incentive would remain for a pharmaceutical manufacturer to engage in research when, if successful, the resulting product cannot be identified by the manufacturer's own trademark or brand name.

"Our entire system of free enterprise is based on brand names. Brand names enable the consumer to reward the product which is proved to be good—and the reward comes through repurchases of the product. If the product proves to be unsatisfactory, the consumer refuses to buy it again. The means for this consumer control is the ability to identify the unworthy product through the trademark or brand name," Dr. Klumpp said. The drug industry has more than kept pace with the tremendous advances in medical care. From the research laboratories of drug manufacturers has come a "seemingly endless flow" of new and more effective medicines. Some 70 per cent of all prescriptions filled today

could not have been filled in 1935; and 42 per cent of today's prescriptions could not have been written just five years ago because the drugs did not exist.

"Never before in the history of medicine have there been so many potent and specific therapeutic agents placed at the disposal of the practicing physician."

Referring to the charge that the industry produces an overabundance of drugs, Dr. Klumpp said:

"Despite all the seeming inefficiencies of free competition, I would rather be deluged with more drugs than I know how to use than be forced to sit idly at the bedside of a patient, doing nothing because there are not enough drugs to save lives or, at the very least, to bring comfort to my patients."

Four Out of Five Participate

Why Not the Fifth?

Why should you be a Participating Physician in Medical-Surgical Plan of New Jersey (Blue Shield)? The answers vary as widely among practitioners as do the philosophies of the individual doctors—a group scarcely noted for their conformity. That there seems to be more *pros* than *cons* to the question is indicated by the fact that more than 81 per cent of all the eligible physicians in New Jersey are Blue Shield Participating Physicians.

Admittedly, some are not completely happy with every aspect of the Plan. But since the total membership continues to grow at a rate greater than the increase in eligible physicians in the state, those whose dissatisfaction is strong enough to cause them to drop out obviously are relatively few.

Nevertheless, there is occasional resistance on the part of the newer and younger doctors to joining the Plan. This page will attempt to provide some answers to the question raised in the first paragraph, and to clarify the matter for both the new doctor and the longer-established one, in and out of the Plan.

The first answer might be: Because it is a direct contribution you can make to the well-being of your fellow-citizens, through implementing the New Jersey Blue Shield pledge—"To make available in New Jersey adequate personal and sympathetic medical care . . . at the lowest cost compatible with efficient service."

"Well," the doctor may say, "this is fine and idealistic; but I already contribute to the well-being of my fellow-citizens through time and talent given in clinics, to medical indigents in wards, and in other ways."

Perhaps the question should be re-phrased:

What are the *advantages* of being a Blue Shield Participating Physician?

There are many—and, truth to tell, they may not all be fully appreciated even by the most loyal supporters of Blue Shield membership. Hence a review seems indicated.

On the practical side, Blue Shield membership by a physician provides ease of collection from Blue Shield subscribers—who now represent an enrollment of over two million New Jersey citizens. Claims are paid (except in unusual circumstances) in about a month, on the average. How many private patients pay as promptly?

Payments are guaranteed. Claims by Eligible Physicians for Eligible Services rendered to enrollees represent guaranteed income to the doctor, not subject to long deferrals in payment, or perhaps nonpayment.

Payments are fair. The fees are decided upon by a committee of doctors on the basis of an *average* fair fee for the services performed; in some complicated cases the fee may seem low; in some simple cases in the same category it may seem over-generous—but as an average it is fair. Perhaps it is sometimes lower than you would charge a private patient; but let's look at that aspect for a moment.

First of all, the fee paid by the Plan is accepted by the Participating Physician as payment in full for his eligible services *only when the subscriber is "under income"*—earning less than $5,000 in the previous twelve months, if enrolled under a Single Contract; or with a combined income for the same period of less than $7,500 for subscriber and spouse, if enrolled under a Family Contract.

Within these income limitations—and the majority of subscribers are—there are not too many who could afford to pay a higher fee to the doctor than the Plan provides; a goodly number would be hard put to meet the same fee from their own resources, and might have

to drag out payments over a long period of time; still others, at the bottom of the scale, would be medical indigents without Blue Shield—and the doctor would end up treating them as "charity cases," in wards and clinics.

As to the "over-income" subscribers, the end result as to total fee chargeable is the same as for private patients. Blue Shield will pay its agreed fee—but the doctor is free to set his own total fee to the patient. The amount in excess of the Blue Shield allowance is payable by the patient. Indeed, such a patient may be regarded by the doctor as in the same category as a private patient—with the one important difference that the physician can count on the Blue Shield portion of his total fee (usually the major portion) being paid promptly.

Blue Shield membership by a doctor is a hedge against a financial depression. Perhaps the younger doctors, not having been through a severe depression, believe that prosperous times are as permanent as the rising and setting of the sun. Were they to hear from some of their older colleagues of times when private patients could pay only 50 cents for a house call; or recompensed a doctor with a dressed chicken for performing an operation, they would realize what a boon guaranteed Blue Shield payments would be if hard times came again.

In broader perspective, there is a most important reason why every doctor should be a Participating Physician. Medical-Surgical Plan is a bulwark against socialized medicine. It is organized medicine's proof that doctors working together can provide voluntary medical care to meet the needs of the people at a cost the subscriber can afford.

Organized through the initiative of The Medical Society of New Jersey, the local Blue Shield Plan exists only so long as a majority of the eligible physicians of the state support it as Participating Physicians. More than half its Trustees must be members of The Medical Society of New Jersey. All Trustees must be approved by the Society prior to election.

Participation in the Plan by a physician not only makes good common sense—it is a demonstration by the physician that he is a part of the national effort by his profession to meet the public need for prepaid medical service *through voluntary methods.*

New Drug Company Launched

The 1961 American Medical Association Meeting served as a launching pad for a vast new drug manufacturing enterprise. This was Philips Roxane, Inc. Its A.M.A. exhibit was in a setting of a Dutch garden, symbolic of its origins. Philips Roxane rises out of a vast network of technologic operations. In the background are the Philips Electronics and Pharmaceutical Industries Corp. and N. V. Philips-Duphar of The Netherlands. The diversified electronic, pharmaceutical and chemical output of these operations have international distribution. Philips-Duphar is a leading source of vitamin D. Currently being developed are studies in organic synthesis and radioactive isotopes.

Philips Roxane has just erected a new plant at its headquarters in St. Joseph, Missouri. Among its current projects is the development of a measles vaccine, now in extensive clinical trial. It is hoped that this vaccine may provide a practical method for mass inoculation. Philips Roxane has also initiated clinical testing of a new progestational agent.

Philips Roxane has several American affiliates. Among these is the Columbus Pharmacal Company of Ohio, the nucleus for marketing in the new organization, which will operate under the Philips Roxane name. Another affiliate is the Anchor Serum Company of St. Joseph. From its extensive facilities (and its experimental farm which serves as a testing ground for its veterinary products) Anchor Serum has established a line of more than 134 pharmaceutical products for animal health.

The scope of Philips Roxane was further extended with the acquisition of Thompson-Hayward Chemical Company, of Kansas City. This company is a leading formulator and supplier of chemicals used in feed supplements and in industry and agriculture.

195th Annual Meeting
The Golden Merit Award Ceremony
May 13, 1961

The Golden Merit Award Ceremony was convened at 3:30 p.m., Dr. Jesse McCall, President, presiding.

THE PRESIDENT: Some time ago I ran across a new word, "serendipity." In the background of Oriental folklore, its derivation is from "Serendip," the ancient name of Ceylon. Its meaning is this: "the ability of finding valuable things unexpectedly." I think the term may have some application here.

On April 28, 1957—four short years ago—Dr. Lewis C. Fritts, whose recent death we all mourn, in addressing the first assembly of this kind, remarked that he was enjoying a privilege which had been denied the 163 men who had preceded him in office and which could not be claimed by any of his successors because there could never be another *first* Golden Merit Award. What he did not say, however, was that The Medical Society of New Jersey had possibly in serendipitous fashion, and after many years, found a suitable mechanism for recognition and commendation for its elder statesmen, a mechanism which would prove to be a source of increasing joy and privilege for each succeeding president. To me that privilege is accorded today.

It has been said in the past that Medicine needs men and women of unselfish dedication and action, men and women of vision and industry, men and women who love Medicine and their fellowmen, and who serve what they love unselfishly. It has also been said that the complete physician must always combine the proper blend of science and art in his practice if he expects properly to fulfill his destiny.

You, our beloved colleagues, have supplied in splendid fashion these qualities of leadership, and you have done it for over a half-century—a half-century filled to the brim with problems of peace and war, problems occurring in such numbers and frequency as to stagger the imagination.

I have been honored highly by The Medical Society of New Jersey over the years. This privilege today is one I shall always treasure. To be able to sit in the favored seats that you occupy, I shall have to maintain health and practice for only twenty-three more years.

May I extend to you, on behalf of The Medical Society of New Jersey, a meaningful and reverent "God bless you." And may I add the heartfelt petition to the Almighty that you be blessed for many more years with a full measure of health and happiness.

The list of recipients is as follows:

ATLANTIC COUNTY
Solon Worth Clark, Atlantic City

BERGEN COUNTY
Edward Porter Essertier, Hackensack

CAMDEN COUNTY
Arthur Jay Casselman, Camden
Leslie Hand Ewing, Berlin

CUMBERLAND COUNTY
James Service Knowles, Millville

ESSEX COUNTY
Laurence A. Cahill, Newark
John Wesley Gray, Newark
James Edward McCormick, Newark
Stanley Henry Mellen, Catskill, New York
Franklin Joseph Tobey, Newark

HUDSON COUNTY
Joseph Irving Berlin, Jersey City
George Joseph Brick, Jersey City
Harry James Perlberg, Jersey City
Carl John Rother, Weehawken
Anthony Gregory Sacco, Union City

HUNTERDON COUNTY
Charles George Boyer, Annandale
Grenelle Bertram Tompkins, Flemington

MERCER COUNTY
Leonard L. Friedmann, Trenton

MONMOUTH COUNTY
John Benedict Makin, Asbury Park
Walter Ames Rullman, Red Bank

MORRIS COUNTY
Frank Huger Pinckney, Convent

OCEAN COUNTY
Robert Buermann, Lakewood
Harry Frederick Hoffman, Metedeconk
Antony Yurevich, Lakewood

PASSAIC COUNTY
William Aloysius Dwyer, Paterson
Ralph James Vreeland, Wyckoff

SUSSEX COUNTY
Thomas Lawrence Pellett, Hamburg

WARREN COUNTY
Frank Aloysius Wolf, Phillipsburg

Obituaries • • •

DR. DAVID B. GERSHENFELD

Northern New Jersey lost one of its pioneer obstetricians on June 21 with the death that day of Dr. David B. Gershenfeld. Born in Europe in 1888, he was brought to the United States at the age of 7. In 1914 he received his M.D. from the old Medico-Chirurgical of Philadelphia (now part of the University of Pennsylvania) and returned to Newark to intern at the St. Barnabas Hospital. After some years of general practice he went to Vienna and Budapest where he did graduate work in obstetrics and gynecology. He then accepted an obstetrical residency at the John Gaston Hospital in Memphis, Tennessee.

Dr. Gershenfeld then devoted himself to his chosen specialty, becoming chief of obstetrics at the Newark Beth Israel Hospital. He was elected a Fellow of the American College of Obstetricians. He also had service as president of the medical staff of the Newark Beth Israel Hospital.

DR. JAMES O. HILL

A career of professional activity combined with civic service came to a close on May 27 with the death that day of former Assemblyman James O. Hill. Dr. Hill received his M.D. at Meharry in 1925, and was a family doctor all through his professional life. He was active in the affairs of the Essex County Medical Society and had several tours of duty as a member of the House of Delegates. He served as president of the New Jersey State Medical Association, and was a charter member of the Republican Council of Essex County. Dr. Hill was a deacon of his church. Active in public service, he was a member of the New Jersey Assembly. Born in 1894, he was 67 years old at the time of his death.

DR. BEN LIPSHUTZ

Dr. Ben Lipshutz, chief of the Welfare Clinics for Children of the City of Bayonne, died on June 23 at the age of 70. Dr. Lipshutz was graduated in 1914 from the Medical College of Virginia, and immediately after completing his internship, volunteered for the U. S. Army, becoming a captain and serving through World War I. He then established an office for general practice in Bayonne, and for 41 years served the people of Hudson County. He was always a general practitioner and family doctor, with a great interest in children and for a decade was Bayonne's senior school physician. When the city established its Child Welfare Clinic, Dr. Lipshutz was named to head the department, a post which he held for a quarter of a century. He was active in the affairs of the Hudson County Medical Society.

DR. FRANK C. McCORMACK

A long-time member of the Society of Surgeons of New Jersey, Dr. Frank C. McCormack, died on June 3 of a coronary thrombosis. He died at the Holy Name Hospital in Teaneck—an institution of which he was one of the founders. He was 72 years old at the time of his death. In 1913 he received his M.D. at Georgetown, and in 1914 he interned at the St. Francis Hospital in Jersey City. The following year he moved to Bergen County, establishing a general practice in Englewood. When the Holy Name Hospital was established, Dr. McCormack became its medical director, and later was named chief of surgery there. He was an F.A.C.S. and had a tour of service as president of the Bergen County Medical Society. He was active in civic and church affairs.

DR. ADELBERT B. TWITCHELL

The last of the founders of the East Orange General Hospital, Aldelbert Birge Twitchell, M.D., died on May 30. Born in 1869, he received his M.D. at Hahnemann in 1898. After an internship in Pittsburgh and graduate work at the Massachusetts General Hospital, he returned to his native Essex County to practice. In 1903 he joined with eight other physicians (all now deceased) to found the East Orange General Hospital. For more than a half century he served the people of the Oranges, retiring in 1948 at the age of 79. At the time of his death he was an emeritus member of the Essex County Medical Society and held a similar status on the staff of the East Orange General Hospital.

Announcements • • •

Seminar on Fractures

September 17, 18, 19, and 20 are the days; Washington, D. C. (Shoreham Hotel) is the place; the American Fracture Association is the sponsor; and $10 is the tuition fee. The program covers every aspect of practical fracture management. For details, write to Dr. Irvin Scott, 117 Washington Street, Sullivan, Indiana. The AAGP allows credit for attendance.

A Day on Nutrition and Oral Health

Sunday, September 24, is the date set for the annual Philadelphia colloquium on nutrition and oral health. Sponsored by the county medical society, the program starts at 9:30 a.m. with papers on soil and water as related to nutrition and health. This is followed by a discussion of the influence of human culture on human diet and the morning concludes with a paper by Olaf Nickelsen on metabolic disorders. At luncheon, Seymour Rinzler will discuss nutrition in relation to heart diseases. Three papers are scheduled for the afternoon: one on stomatitis, one on oral manifestations of blood dyscrasias, and one on nutrition and periodontal disease.

The seminar will be held at the Evans Institute, 43rd and Spruce Streets in Philadelphia. You are invited.

Endocrinology and Metabolism

An intensive 5-day course in endocrinology and metabolism is scheduled for the week of October 2 at the National Institute of Health in Bethesda, Maryland, which is just north of Washington, D.C. Fee is $100. For further details, write to Dr. Roy Hertz, Building 10, National Institute of Health, Bethesda, Md.

Course in Hypnosis

A graduate course in medical hypnosis is offered by the University of Pennsylvania. There will be 24 weekly afternoon sessions beginning October 4. It is the only course offered which meets recommendations made by the American Medical Association.

During the first part of the course, basic concepts of hypnotism will be taught through lectures on psychiatry and hypnosis, demonstrations, and supervised practical work in hypnosis. Then will come clinical applications of hypnosis. Here there will be sessions limited to psychiatrists and others limited to general practitioners, dentists, and other specialists.

The course will be given at the Institute of the Pennsylvania Hospital, 111 North 49th Street, Philadelphia. The teaching staff is headed by Lauren H. Smith, M.D., Professor of Psychiatry at the Graduate School of Medicine. The staff will include Dr. Harold Rosen, head of the American Medical Association's Committee on Hypnosis. Tuition fee is $375. The course runs from 3 to 7 p.m., October 4, 1961, through March 28, 1962. Make checks payable to "Trustees, University of Pennsylvania." For further details, write to Graduate School of Medicine, 237 Medical Laboratories, University of Pennsylvania, Philadelphia 4, Penna.

Gastroenterology Course

October 26, 27 and 28 are the days for the practical course in gastroenterology sponsored by the American College of Gastroenterology. The meetings will be in Cleveland, and a star-studded faculty has been assembled. Program includes material and demonstrations in cinegastrophotography, x-ray interpretation, clinical diagnosis of lesions of tract, and technics of treatment. For further details write to American College of Gastroenterology at 33 West 60 Street, New York 23, N. Y.

Medical-Dental Cancer Seminar

On November 4 and 5, at the Haddon Hall, in Atlantic City, the New Jersey Division of the American Cancer Society will sponsor a medical-dental cancer colloquium. For details write to American Cancer Society, 623 Central Avenue, Newark 7, N. J.

Ophthalmic Surgery

An intensive and practical seminar-demonstration in surgery of the eye is scheduled for February 5 through 9, 1962. The principal demonstrator will be the distinguished Spanish ophthalmic surgeon, Joaquin Barraquer, who is coming from Barcelona for this purpose. Sponsored by the New York Eye and Ear Infirmary, the course is available at a tuition fee of $75. The program will be held in New York City. For details, write to the Registrar, Institute of Ophthalmology, Eye and Ear Infirmary, 218 Second Avenue, New York 3, N. Y.

Urology Award

Annual cash awards totalling $1000 await physicians who write the three best papers reporting clinical or laboratory research in urology. Competition is limited to interns and residents and to practitioners who have been out of medical school less than eleven years. For details write to American Urologic Association at 1120 N. Charles Street, Baltimore 1, Maryland. Deadline for this contest is November 15, 1961.

Do You Have a Paper for the Next Annual Meeting?

The Committee on Annual Meeting and various section chairmen want the program to represent real membership participation. So, if you have any ideas about the content of the program for any section, notify the Executive Offices. If you have a paper of your own, send the data to the Annual Meeting Committee, care of Executive Offices, The Medical Society of New Jersey, Box 904, Trenton 5, N. J. The committee will want to know the title and subject of the paper, the time you would need to present it, whether you will need lantern slide, moving picture, or blackboard facilities, and in what Section the presentation would seem most appropriate.

New Jersey Diplomates in Obstetrics and Gynecology

The following New Jersey doctors were certified by the American Board of Obstetrics and Gynecology on April 15, 1961:

Jerome Abrams, Plainfield
Gerald S. Barad, Flemington
Richard S. Battaglia, Elizabeth
Jerald R. Cureton, Red Bank
William McK. Dawson, Metuchen
Vincent P. De Pietro, Union City
Joseph Dortch, Vineland
Edward Foord, Burlington
James Fox, Teaneck
Dominic A. Introcaso, Elizabeth
Burton A. Krumholz, Levittown
William C. Love, Woodbury
Irving I. Luftman, New Brunswick
Robert T. Miller, Oradell
Thomas A. Noone, Haddon Heights
Douglas W. Payne, Asbury Park
Walter P. Peter, Jr., Plainfield
Francis P. Salvatore, Englewood
Hanfred R. Seela, Ridgewood
Richard H. Small, Red Bank
William C. Soule, Tenafly
Gilbert R. Sugarman, Millburn

Letters to The Journal • • •

Last year in the *Archives of Dermatology*, J. M. Knox published a paper on curettage for the treatment of certain kinds of skin cancer. An abstract of this was published in our June JOURNAL. In this connection the following note comes from William O. Wuester, M.D., of Elizabeth:

I would like to comment on the short article entitled "Curettage in Skin Cancer," page 255, June issue of THE JOURNAL. This method is not to be recommended for universal application of skin cancer. Our files are filled with recurrent carcinomas treated in this manner, some of them serious enough to cause loss of the eye. The cosmetic result has left much to be desired. Past criticism, in my opinion, has been justified.

County Society Reports • • •

Cumberland

The *Cumberland County Medical Society* was the guest of the Owens-Illinois Glass Company for their June 13 meeting that was held in the Onlzed Cabin at Palatine Lake at 2:30 p.m., with Dr. Alfred O. Davies presiding. The attendance at the meeting surpassed that of any preceding meeting during the year.

John Frohwein, M.D., was accepted for Active membership by transfer from the Philadelphia County Medical Society.

Mary Bacon, M.D., chairman of the County Maternal and Infant Welfare Committee, reported that the Bridgeton Hospital sought out the honor and has been selected as one of 100 hospitals to conduct a one-year pilot study for the American Medical Association. Dr. Bacon further stated that the Committee hopes to get an early October start and coordinate Cumberland County Maternal Welfare interests with two major projects:

(1) The objectives of the New Jersey State Committee on Maternal Welfare.
(2) The Perinatal Mortality Studies of the American Medical Association.

Enhancing the installation of the elected officers of April 11, was a sumptuous meal served by the fine Owens-Illinois staff.

LEONARD G. SCOTT, M.D.

Reporter

Relief of Widows and Orphans

At the annual meeting of the *Society for the Relief of Widows and Orphans of Medical Men of New Jersey*, the following officers were elected for 1961-62: President: Berthold Schwarz, M.D.; Vice-President: James E. D. Gardam, M.D.; Treasurer: George Fay Stoll, M.D.; Assistant Treasurer: Ogden Carter, M.D.; Custodian of Permanent Fund: Herbert A. Schulte, M.D.; Counsel: Charles Harden, LL.B.: Secretary: Joseph W. Gardam, M.D. and Trustee: George Potekhen, M.D., to fill an unexpired term for 1959-1962.

The Trustees are pleased to report the accession of 129 new members this year. With 21 deaths offsetting this gain we now have 769 members, the highest on our rolls in our 80 years of existence. Payment to each widow upon the death of her husband is now at an all time high of $700. The Society assesses its members a single dollar upon the death of a member. Payment is made to a widow within a very few days of reporting the death. The balance of the sums collected pay the costs of running the Society and also increases the Permanent Fund, the earnings from which are used to help needy widows or orphans of former members. We urge all physicians who are not members to write for an application blank and help take part in this great work.

JOSEPH W. GARDAM, M.D.

Secretary

Book Reviews • • •

Congenital Malformations of the Heart. Volume 1: General Considerations. By Helen B. Taussig, M.D. Cambridge 1960. Harvard University Press. Pp. 204, illus. ($4.75)

This volume meets the need of the physician in the study of congenital heart disease. There has been a great change in the approach to this subject since 1937 when the first successful operation for patent ductus was performed. No longer can a physician be satisfied with a general diagnosis of congenital heart disease; he must try to arrive at a more specific diagnosis in order that he may give consideration to the possibility of surgical correction. Responsibility for diagnosis may be in the hands of the general practitioner, pediatrician, internist or cardiologist.

This volume, by one of the great pioneers in the study of congenital malformations of the heart, is written primarily for medical students and general practitioners. The author's aim is to orient the reader in the basic methods of diagnosis. She emphasizes physical examination, x-ray and fluoroscopy, as well as angiocardiology. Dr. Taussig has added her wealth of personal experience in her study of thousands of cases in order to help the physician arrive at a diagnosis as to the advisability of surgical correction.

Chapter V, which deals with medical care of these patients, is well presented and should prove to be helpful. The book is well illustrated and the diagrams are consistent with the text.

This volume is highly recommended to the medical profession, not only as a reference book to be kept on a library shelf, but to be read and reread. It will be worth the reader's time. Volume 2, to be published shortly, will give detailed information on each of the specific malformations. It is being prepared, particularly for the internist, cardiologist and pediatrician.

JEROME G. KAUFMAN, M.D.

Medical Care of the Adolescent. By J. Roswell Gallagher, M.D. New York 1960. Appleton-Century-Crofts, Inc. Pp. 384, 43 illus. ($10.00)

In an era already dedicated to overspecialization, one welcomes the appearance of a work developed on a horizontal level. The study of the adolescent, bounded primarily by age alone, embraces many well defined specialties in which the disease entity is well understood in the late stages with little is known about the early development.

Understanding the adolescent predicates an understanding of the "normal" with the many variations encountered in growth and development. One must, in addition, become attuned to the adolescent psychologically, as well as physiologically and must be prepared to deal with their impulsive emotional as well as anatomic variants.

The opening chapters are devoted to generalities concerning establishment of rapport, history taking, physical appraisal, and growth and development. The author then reviews the more common clinical entities—many of which are continued over from the field of pediatrics. This publication is valuable not only as a factual presentation but also as an underlining of the understanding of the problems of this age group. The entire book is a valuable asset to the library of any physician interested in the problems of the adolescent.

WALTER L. MITCHELL, JR., M.D.

Regulation of the Inorganic Ion Content of Cells. Ciba Foundation Study Group No. 5. Edited by G. E. W. Wolstenholme, M.D. and Cecilia M. O'Connor, B.Sc. Boston 1960 Little, Brown and Company. Pp. 100, with 16 illus.

This manuscript constitutes the record of discussions among physiologists who met under the auspices of the Ciba Foundation to discuss the regulation of the inorganic ion content of cells. The text will have its greatest appeal to advanced students of physiology, and especially to those interested in muscles, nerves, and cellular metabolism.

The paper of H. Ussing (from the Institute of Biologic Chemistry, of the University of Copenhagen) dealing with the osmotic regulation of ion transportation of the frog skin epithelium, was of particular interest; and in the opinion of the reviewer, should have constituted the first chapter of the volume. Numerous mathematical formulae, dealing with advanced physiological concepts of ion regulation, are reproduced as well as charts representing various experimental curves of physiological data.

The chapter by Rothstein, dealing with the factors determining the inorganic ion content of yeast cells, (which was in part supported by the U. S. Atomic Energy Commission) indicates the interest of this agency in yeast cells as a possible source of nutrient energy for space travelers.

The volume will have little appeal to the general medical profession; but will be of great value to students of advanced physiology.

THOMAS K. RATHMELL, M.D.

Multilingual Manual for Medical Interpreting. Louis R. Del Guercio, M.D. New York, 1960. Pacific Printing Company. Pp. 160.

Dr. Del Guercio has done us all a service in developing this compact and usable polyglot for doctors. The text covers six languages: French, Russian, Spanish, German, Polish and Italian. For each there are 100 common medical questions, the words in the language desired, and simple phonetic equivalent. A thumb index makes reference ready and swift. The whole gamut of medical history is covered. The author cannot give us all possible answers in all these tongues—and even if he did, most of us could not understand the answers. He resorts, instead, to a simple device. He phrases every question so that the answer may be given as *yes* or *no*—and he tells you what these words are in those languages. More likely the answer will be in a nonverbal shrug of the shoulders or nodding of the head. In the wonderfully rich, many-strained culture which is the warp and woof of America, there is need for a good little foreign-language guide. To meet that need this pocket-size volume is recommended.

HENRY A. DAVIDSON, M.D.

Resuscitation of the Newborn Infant. Edited by Harold Abramson, M.D. St. Louis 1960. C. V. Mosby Co. Pp. 264. ($10.00)

Never before has this reviewer seen, in one volume, such a fine comprehensive discussion of the resuscitation of the newborn. With the help of other specialists, Dr. Anderson has developed a practical guide for the obstetrician, general practitioner, pediatrician and anesthesiologist, for the urgent situations that arise in the first hour of life.

The chapter dealing with the pathology of the fetus and newborn infant, with neonatal respiratory failure and the interpretation of pathologic findings is outstanding. The discussion of the value of autopsies on newborn infants and the emphasis on the thorough examination of the placenta and umbilical cord are of great value from the point of view of treatment.

The factors predisposing to fetal anoxia and neonatal asphyxia are presented in outline form to aid one in the rapid accurate diagnoses of perinatal disability present.

Beginning with the history and physical examination of the mother, he goes on with a discussion of the obstetric factors contributing to perinatal disability and their management, and a well written chapter on obstetric analgesia and anesthesia.

To me, as a pediatrician, the chapters "The First Sixty Seconds of Life," "Resuscitation Procedures in the Delivery Room," and "The Immediate Examination of the Newborn Infant in the Delivery Room" seemed invaluable.

Throughout this book, Dr. Abramson keeps reminding us that there are many infants who, in spite of clinical signs of fetal distress are in good condition at birth, and might survive if we heeded these warning signs. It is the aim of this presentation to make us aware of the physiology, pathology and clinical picture of the newborn infant, so that we may be better able to help these infants to breathe and to live.

A. S. FINKELSTEIN, M. D.

Communicable and Infectious Diseases. Franklin H. Top, M.D. with 22 collaborators. St. Louis 1960. Mosby. Ed. 4. Pp. 810, with 15 color plates and 123 figures. ($20.00)

This popular book has been rewritten and brought up to date. An impressive panel of associates has given the book an excellent background. Diseases are listed by portal of entry: a good classification. The section devoted to prevention adequately covers that field. This is also true of the material on serum reactions. The portion of the book devoted to antibiotics (mode of actions and sensitivity) is excellent. There are good chapters on management of communicable diseases in the hospitals. More stress should have been laid on the need of additional beds, and control in the general hospitals. Isolation hospitals are outmoded. The chapters devoted to the specific diseases reflect the labors of many experts. The book in its entirety is a useful *vade mecum* for the physician who devotes time to health department work.

JOSEPH W. GARDAM, M.D.

Clinical Applications of Cardiopulmonary Physiology. By M. Henry Williams, Jr., M.D. New York 1960. Pp. 233, illus. ($7.50)

Stirring evolutionary advances in the technics for the study of the physiology of the heart and lungs have contributed to the newly won laurels in the prevention and treatment of cardiopulmonary conditions.

This book offers a concise presentation of laboratory tests of cardiorespiratory function which will prove helpful to the physician in diagnosis, evaluation, and treatment. This text is a distillation of the enormous pool of physiologic data, graphs and formulae available in the scientific literature.

The first part of the book concerns itself with the normal cardiopulmonary physiology and an evaluation of structure by physiologic technics. Congenital and acquired heart disease and heart failure are discussed in the light of the newer knowledge, with special emphasis on pathogenesis, indications for definitive studies and evaluation of results of treatment—including surgery.

Pulmonary function and its disturbances—both acute and chronic—are dealt with in detail with a lucid discussion of the chief symptoms of hypoxia, hypoxemia, cyanosis and dyspnea.

This book is adequately, although not voluminously illustrated, and should find a welcome place on the desk of any internist, surgeon or general practitioner interested in a better and clearer understanding of diseases of the heart and lungs.

SOL PARENT, M.D.

Synopsis of Pathology. By W. A. D. Anderson, M.D. St. Louis 1960. C. V. Mosby Co. Ed. 5. Pp. 876, 414 illus. ($9.25)

The author of this concise and comprehensive presentation of pathology is to be congratulated for not succumbing to the temptation of including considerably more detail. This would have defeated his purpose of maintaining, (as in all previous editions) the basic fundamentals of pathology with no elaboration. This was not an easy task with the extensive literature accumulated since the last edition.

Dr. Anderson includes such new syndromes as pulmonary alveolar proteinosis, pneumocystitis, pneumonitis, cat scratch disease, familial chronic idiopathic jaundice, kwashiorkor, epidemic hemorrhagic fever, thrombotic thrombocytopenic purpura, aldosteronism and the carcinoid syndrome. In many other diseases, new information has been critically reviewed. This includes the field of neoplasms, as well as inflammatory, viral, toxic, protozoal, helminthic, congenital and vascular diseases.

This revised edition gives basic pathology succintly and clearly so that it is a book of considerable usefulness to pathologists, surgeons and internists. It is an excellent review for medical students.

HAROLD GRUBIN, M. D.

The Senescent in Industry. George C. Dow, M.D. Boston, 1960. American Geriatrics Society. Pp. 94. (Price not stated)

The failure to employ more than half of our over-65 citizens is costing the economy 3 billion dollars a year in lost productivity. This is above the 8 billion costs of benefits. World War II experience showed that workers over the age of 65 had better records than their juniors in terms of injuries, absenteeism, quality of work, ability to follow instructions and stability. And every employee who works beyond the "retirement" age, saves his company some pension money.

To promote the employment of older people, we physicians must know how to appraise their industrial fitness. And this is one aim of this slender volume. Dr. Dow takes the reader step-by-step through the technic of testing the working capacity of a senior citizen. A useful "capacity evaluation survey" form is included. As an added benefit, the book includes a chart of medical standards for automobile drivers.

This unique book comes out of studies made by the American Geriatrics Society and its National Advisory Committee. It is extremely useful in itself, and has the added asset of offering a note of optimism in a field that is often colored by a feeling of hopelessness. It is good for us to remember that what makes old age sad is not the loss of ability but the loss of hope.

ULYSSES M. FRANK, M.D.

Problems of Medicine and Biology in Experiments on Monkeys. Edited by I. A. Utkin, M.D. Translated from the Russian by Ruth Schachter, M.S. New York 1960. The Pergamon Press. Pp. 275. ($7.50)

During the past decade, a considerable amount of experimental work has been done in Russia, using monkeys and baboons as subject animals. Reports from this "medico-biologic station" are bound together to form this book. The reports include those on atherosclerosis, diabetes, dysentery, measles, antibiotic effectiveness, poliomyelitis, hematopoiesis, and a variety of neurologic, neurophysiologic, and "experimental neurotic" projects. The work is solid, somewhat pedestrian in style, and extremely detailed. It will be a thought-provoker for the advanced experimental biologist.

FELIX A. UCKO, M.D.

Rypin's Medical Licensure Examinations. Edited by W. L. Bierring, M.D. Philadelphia 1960. Lippincott. Ed. 9. Pp. 804. ($11.00)

Not just a quiz book, this ninth edition of "Rypin's" first gives the facts in the various branches of medicine, surgery and the basic sciences. Each section is then followed by a series of searching questions—the answers to which can be unearthed if the student will go through the book carefully. In addition, there is an interesting chapter on the history and technics of examinations. There are no illustrations, and this reviewer was unable to find any material on medical jurisprudence or infant feeding: perhaps rather trivial defects in this otherwise excellent work. It makes a good reference manual for the practitioner, as well as a preparation source for examination applicants. Its survival through nine editions is all the bouquet it needs.

VICTOR HUBERMAN, M.D.

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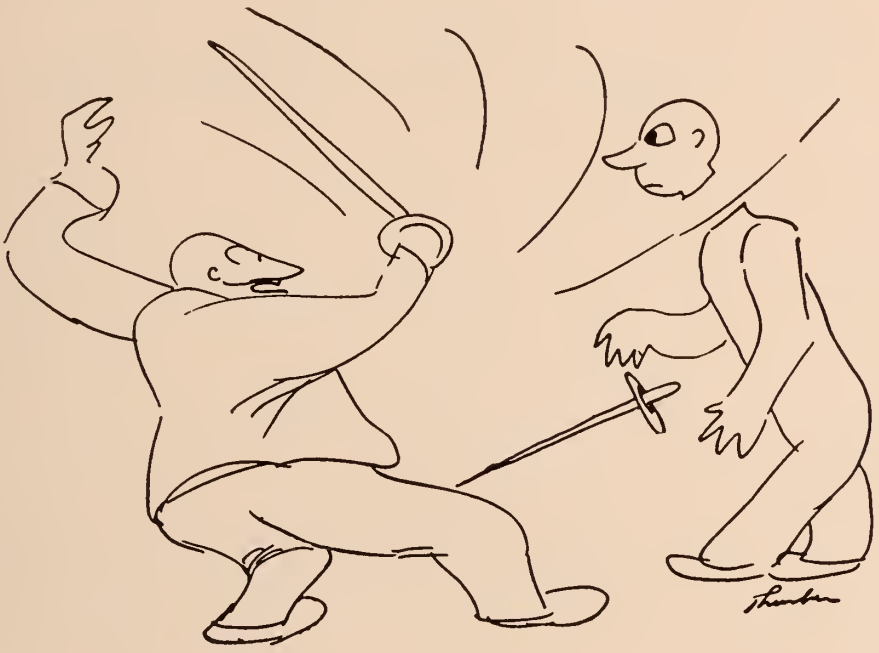
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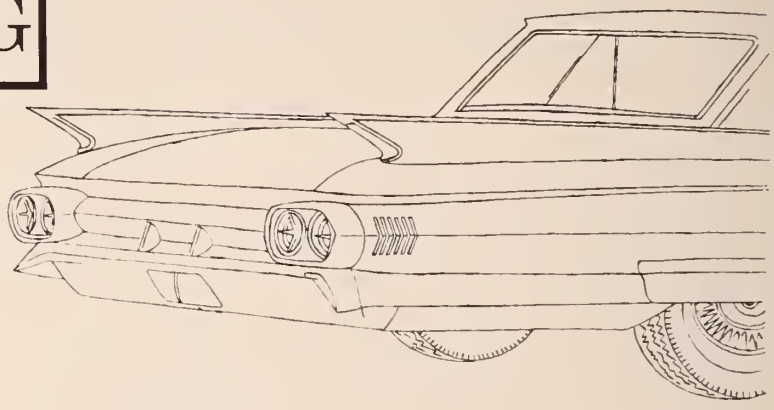
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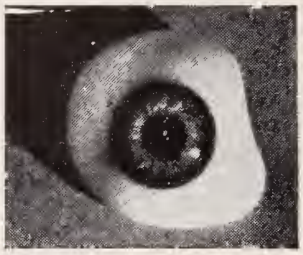
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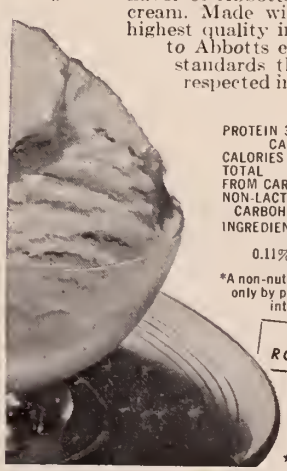
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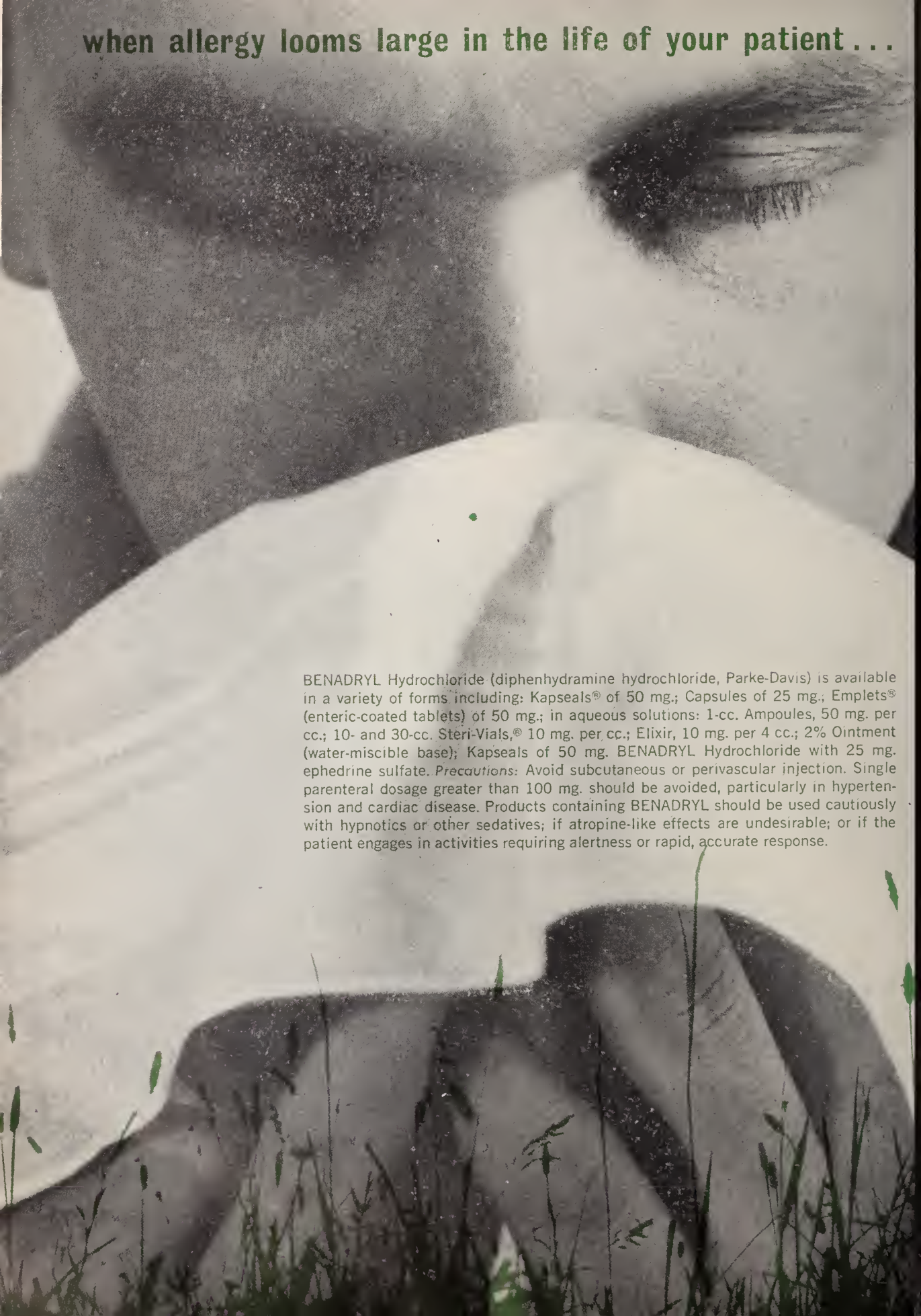
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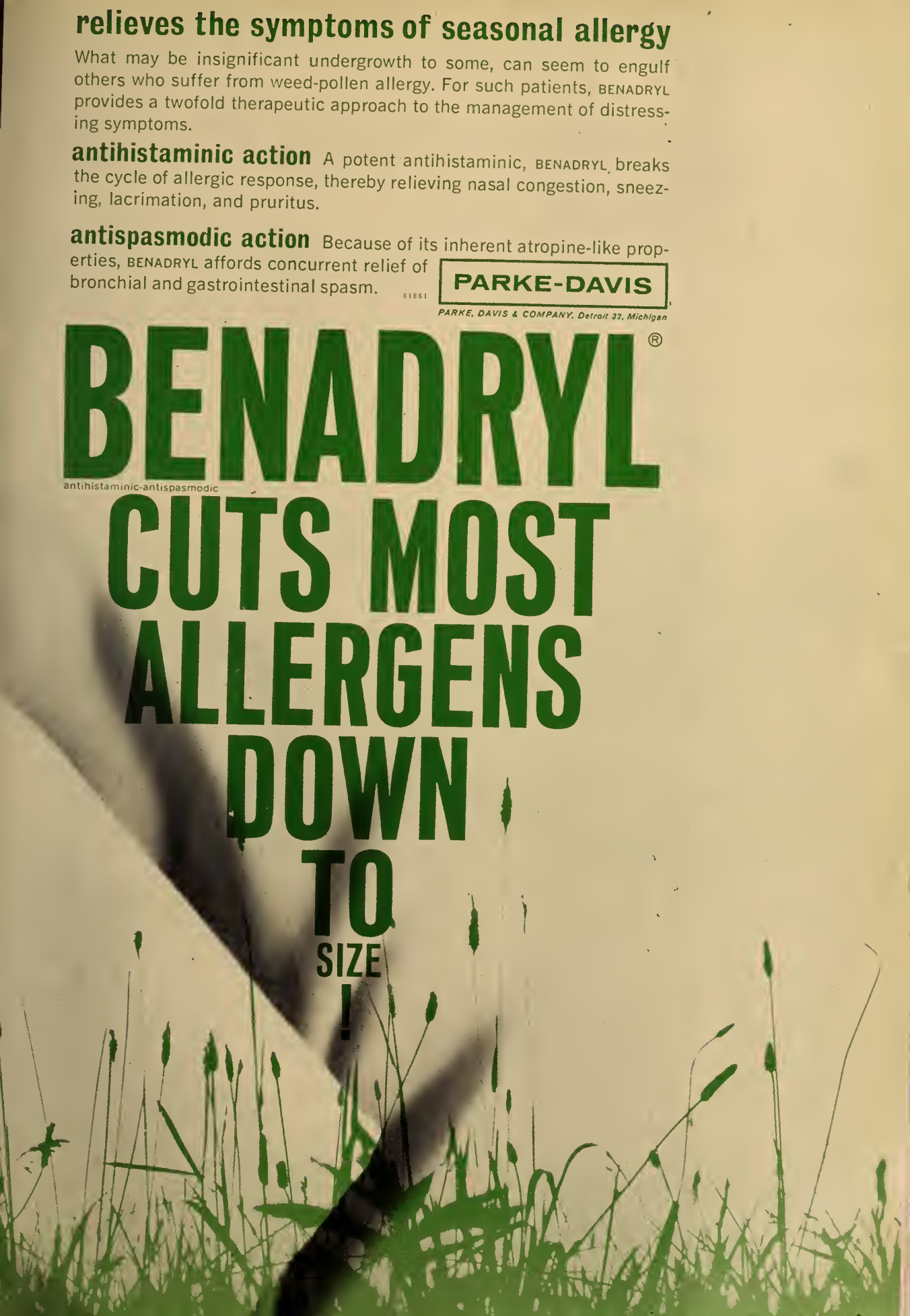
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VOL. 58, No. 9 SEPTEMBER, 1961 Subscriptions, $3.00 per year
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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

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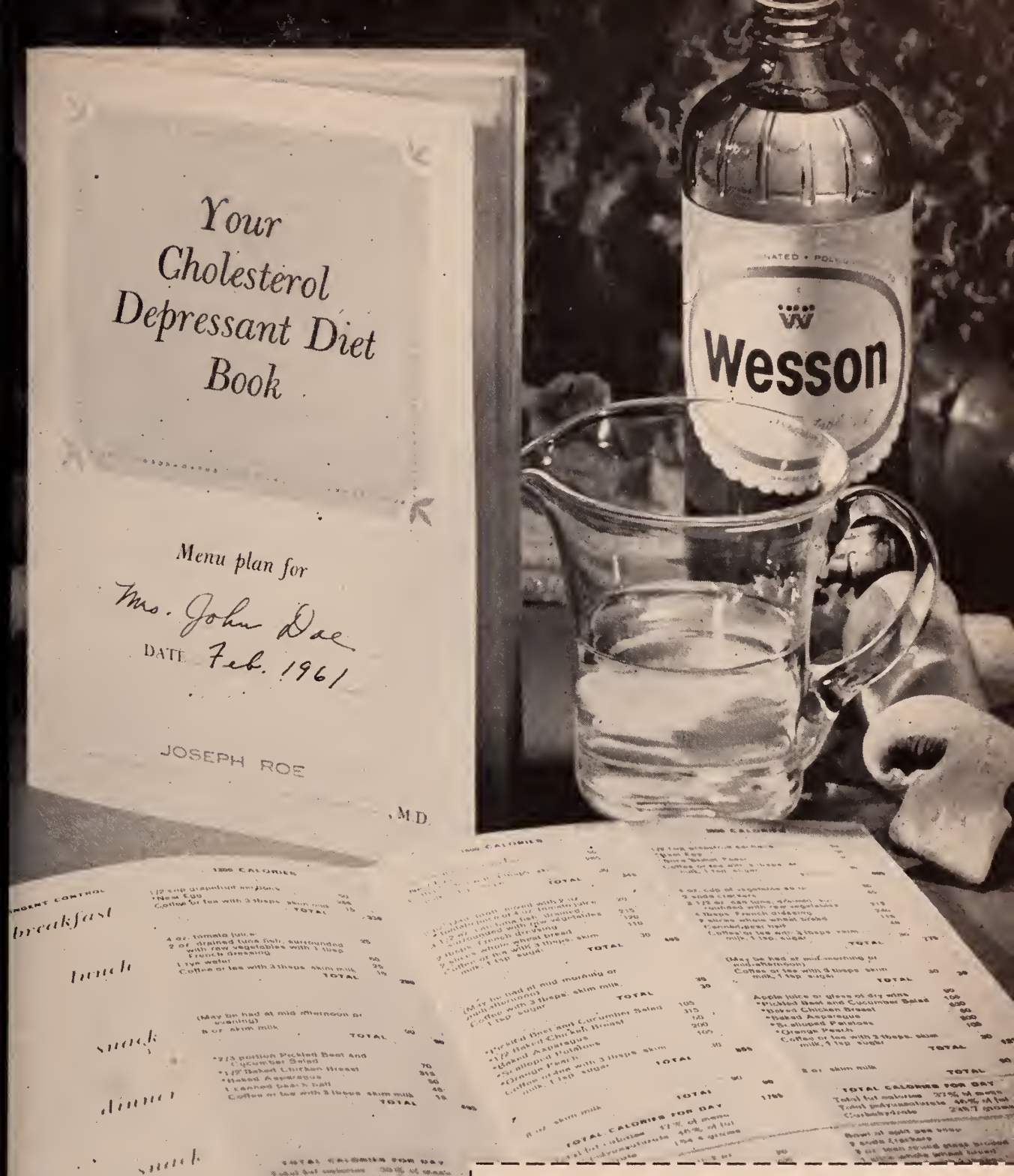
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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A line connecting successive urine-sugar readings reveals at a glance how well diabetics are cooperating. Each CLINITEST Set and tablet refill contains this physician-patient aid. 01561

AMES
COMPANY, INC
Elkhart Indiana

leads to visceral distress...

restore normal smooth muscle function

through dependable autonomic sedation

The uniformly dependable antispasmodic-sedative action of DONNATAL relieves hypermotility, hypertonicity and spasticity of smooth muscle **at all levels** of the gastrointestinal tract: pharynx, esophagus, stomach, small intestine and large intestine.

Donnatal incorporates **natural** belladonna alkaloids in optimal synergistic ratio, supplemented by phenobarbital in low dosage, for concurrent control of both somatogenic and psychogenic factors.

For dosage flexibility—

DONNATAL® TABLETS CAPSULES ELIXIR

Antispasmodic maintenance under a t.i.d. dosage regimen

Robins

For prolonged effects—

DONNATAL® EXTENTABS®

All-day or all-night spasmolytic benefits on a single dose, equal to the effect of one DONNATAL tablet uniformly sustained for 10 to 12 hours.

	In each Tablet, Capsule, or 5 cc. Elixir	In each Extentab
Hyoscyamine sulfate	0.1037 mg.	0.3111 mg.
Atropine sulfate	0.0194 mg.	0.0582 mg.
Hyoscine hydrobromide	0.0065 mg.	0.0195 mg.
Phenobarbital	(¼ gr.) 16.2 mg.	(¾ gr.) 48.6 mg.

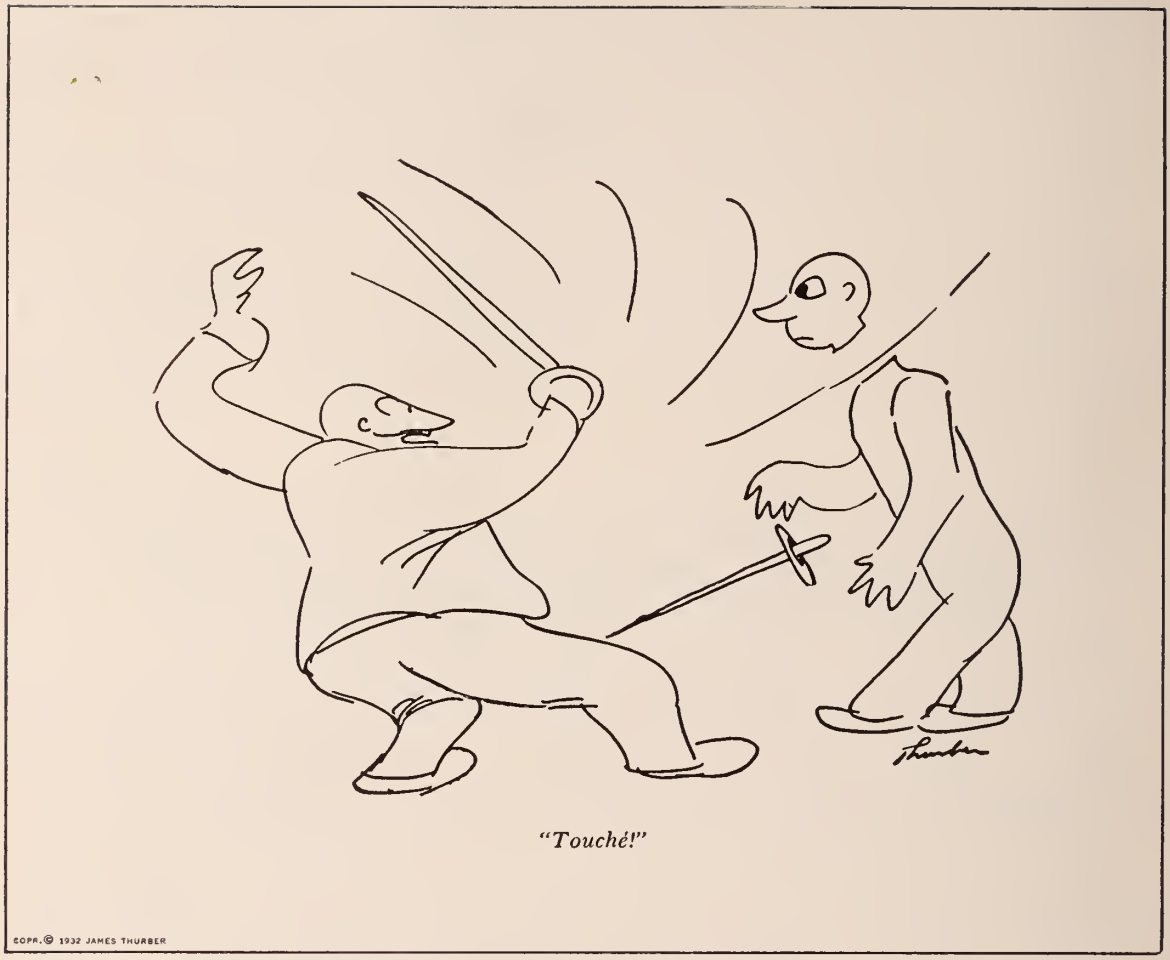
DONNATAL® Robins

natural belladonna alkaloids with phenobarbital

Prescribed by more physicians than any other antispasmodic

A. H. ROBINS CO., INC.
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Making today's medicines with integrity... seeking tomorrow's with persistence



"Touché!"

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For a better way to treat headache,
prescribe **Trancoprin®**

How Trancoprin relieves pain: Because most pain is accompanied by muscle spasm and tension, good medical practice suggests use of an analgesic that will relax skeletal muscles as well as dim pain perception. Such an analgesic is Trancoprin — a combination of aspirin and Trancopal®, a proved, safe, skeletal muscle relaxant and tranquilizer. Trancoprin can be prescribed for any pain, except pain of such severity that a narcotic is needed.

Dosage: Adults, 2 tablets three or four times daily; children (5 to 12 years), 1 tablet three or four times daily. Each tablet contains 300 mg. of aspirin and 50 mg. of Trancopal (brand of chlormezanone). Bottles of 100 tablets.

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New York 18, N.Y. 1572M

introducing...nutritional support in convenient, tasty, liquid form to supplement inadequate diets... to replace skipped meals



Nutrament™

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nutritionally complete food

a nutritious meal, ready to drink

utritional support is often needed for:

areless or irregular eaters—who skip breakfast or unch or do not eat properly because of busy schedules or faulty eating habits.

hildren—who need increased basic nutrients during onvalescence[1] or during difficult feeding periods, such as after tonsillectomies.[2]

dolescents—who require nutritional support because of growth needs and poor dietary selection.[3]

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eriatric patients and others—who cannot or will not naintain proper nutrition because of poor dentition, aulty eating habits, or lack of interest in eating.[5]

ospital patients—Nutrament liquid can serve as an xcellent and convenient source of nourishment.

nd in Oral, Dental or Surgical conditions—which nterfere with or prevent consumption of solid food.

readily accepted by patients

Nutrament liquid requires no special preparation. Smooth texture and appealing taste of Nutrament make it readily acceptable. Equally delicious served hot or cold. Nutrament also has a high satiety value.

supplied

In 12½ fl. oz. cans, chocolate and vanilla flavors. Conveniently available at drug and food stores.

offers a scientifically balanced ratio of carbohydrate, protein, and fat. Each 12½ fl. oz. can of Nutrament liquid provides 400 calories. Caloric distribution: protein–20% (20 Gm.); carbohydrate–50% (50 Gm.); fat–30% (13.3 Gm.); plus the following vitamins and minerals:

		% MDR
Vitamin A (U.S.P. Units)	1250	30
Vitamin D (U.S.P. Units)	125	30
Vitamin C, mg.	50	166
Thiamine, mg.	0.5	50
Riboflavin, mg.	0.6	50
Niacinamide, mg.	5	50
Calcium, Gm.	0.5	67
Phosphorus, Gm.	0.4	53
Iron, mg.	4	40
Iodine, mcg.	60	60

Vitamin E (Int. Units)	2.5
Pyridoxine, mg.	0.4
Vitamin B_{12}, mcg.	0.5
Calcium pantothenate, mg.	2
Sodium, Gm.	0.2
Potassium, Gm.	0.9
Copper, mg.	0.5
Manganese, mg.	1
Fiber, Gm.	0.55

ingredients: Whole milk, skim milk, sugar, soy flour, Dextri-Maltose® (maltose and dextrins derived from enzymic action of choice barley malt on selected corn flour), starch, chondrus extract, sodium alginate, vitamin A palmitate, calciferol, sodium ascorbate, thiamine hydrochloride, niacinamide, ferrous sulfate, sodium iodide, *d*-alpha-tocopheryl acetate, pyridoxine hydrochloride, cyanocobalamin, calcium pantothenate, salt, cupric carbonate, manganese sulfate, cocoa and/or imitation vanilla flavor.

references: (1) Nelson, W. E.: Textbook of Pediatrics, ed. 7, Philadelphia, W. B. Saunders Company, pp. 231-233, 1959. (2) Parrott, R. H., and Nelson, W. E.: *ibid.*, p. 759. (3) Johnston, J. A.: Ann. New York Acad. Sc. *69*:881-901 (Jan. 10) 1958. (4) Burke, B. S., and Kirkwood, S. B., in Greenhill, J. P.: Obstetrics, ed. 12, Philadelphia, W. B. Saunders Company, 1960, pp. 126-131. (5) Skillman, T. G.; Hamwi, G. J., and May, C.: Geriatrics *15*:464-472 (June) 1960.

57061

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A DIVISION OF
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Quality products from nutritional research

NEW...made from 100% corn oil UNSALTED MARGARINE FOR HYPERTENSIVE PATIENTS

* contains only 10 mgs. of sodium per 100 grams
* contains 50% liquid corn oil and 50% partially hydrogenated corn oil
* has 30% linoleic acid—10 times that of butter

Because of the relationship of high-sodium intake to elevated blood pressure, new Fleischmann's Unsalted Corn Oil Margarine will prove to be a valuable addition to the dietary regimen of your hypertensive patients. It contains only 10 mgs. of sodium per 100 grams.

Fleischmann's Unsalted Margarine is made from 100% corn oil and contains both liquid corn oil and partially hydrogenated corn oil. Its linoleic acid content of 30% is three times higher than the 10% of regular margarines and ten times higher than the 3% of butter. This is the *only* unsalted margarine made from 100% corn oil.

The substitution of Fleischmann's Unsalted Corn Oil Margarine for butter or ordinary margarines in your hypertensive patients' dietary regimen has the added advantage of increasing their intake of high polyunsaturates . . . important because of their association with hypertension and atherosclerosis.

If your hypertensive patient needs sodium restriction, recommend Fleischmann's Unsalted. It has a light, delicate taste that he'll like. Tell him that it is available in his grocer's frozen food case.

Write now for physician booklet of 5 coupons—each coupon redeemable by your patient for 1 lb. of Fleischmann's Unsalted Margarine. Address Fleischmann's Unsalted Margarine, 625 Madison Avenue, N. Y. 22, N. Y. *Distribution presently limited in some areas.*

In line with the suggestion of the American Heart Association to manufacturers, we are listing the fatty acid composition of Fleischmann's Unsalted (Sweet) Margarine:

Unsaturated Fatty Acids:	
Polyunsaturates	30%
Monounsaturates	50%
Saturated Fatty Acids . . .	20%
	100%

AVERAGE DAILY INTAKE
Two Ounces or Eight Pats of Fleischmann's Corn Oil Margarine Will Supply

Corn Oil—Liquid	22.7 Gm.
Corn Oil—Partially Hydrogenated . . .	22.7 Gm.
Iodine Value	90-95
Sodium (dietetically sodium-free) . . .	6 Mgs.
Linoleic Acid	13.6 Gm.
Vitamin A (Adult's Need)	47%
Vitamin A (Child's Need)	62%
Vitamin D (Adult's and Child's Need) . . .	62%

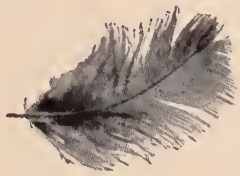
Fleischmann's



In the Grocer's Frozen Food Case

ONLY UNSALTED MARGARINE MADE FROM 100% CORN OIL

It takes so little to trigger an asthmatic attack...



it takes so little MORE to control it... the simple addition of ATARAX to your classic anti-asthmatic therapy increases therapeutic success even in difficult patients

Each MARAX tablet contains: ATARAX® (hydroxyzine HCl) 10 mg.—an antihistaminic tranquilizer beneficial in bronchial asthma and allergy.[1] Ephedrine sulfate 25 mg.—to reduce congestion. Theophylline 130 mg.—for bronchospasmolysis.

"Superiority of [MARAX] seems attributable to the inclusion in it of hydroxyzine in place of the conventional barbiturates."[2] In a series of patients generally refractory to the usual antiasthmatics, and who required steroids in order to obtain temporary relief, 70% showed good to excellent symptomatic relief with MARAX. Patients "...slept more comfortably and breathed more easily. The characteristic asthma wheeze was either markedly reduced or entirely relieved."[3]

If your asthma patients do not respond to standard therapy, they may need the "little MORE" that MARAX offers.

MARAX®

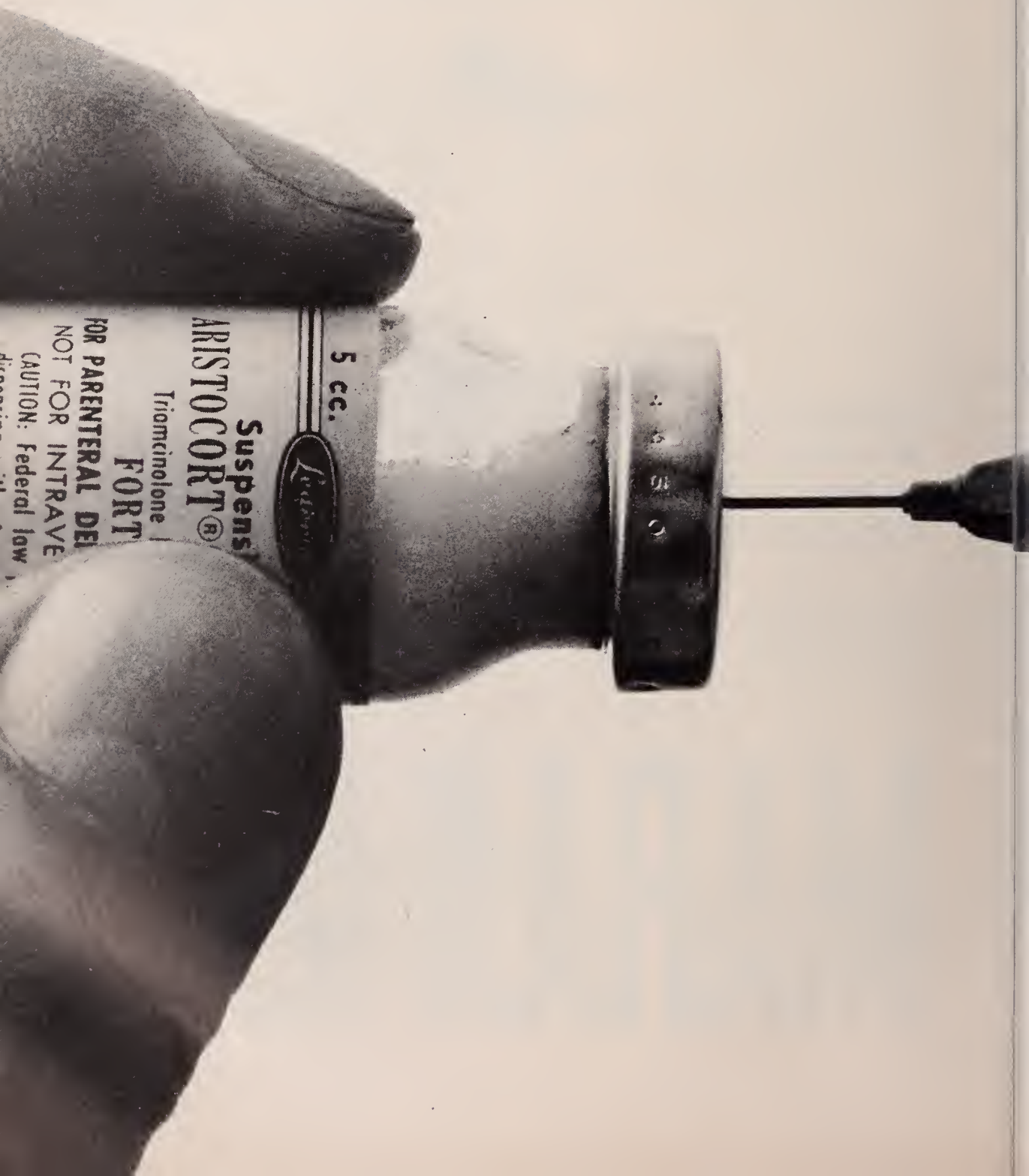
Usual adult dosage: One tablet 2 to 4 times daily. Full prescription information on request. Supplied: Bottles of 100 light blue, scored tablets. Prescription only.

References: 1. Santos, I. M. H., and Unger, L.: Ann. Allergy 18:172 (Feb.) 1960. 2. Charlton, J. D.: Ann. Allergy, In press. 3. Shaftel, H. E.: Clin. Med. 7:1841 (Sept.) 1960.

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Science for the World's Well-Being®

when your patient needs
a potent steroid... simplified control
of subacute or chronic disease...



New Aristocort® Forte

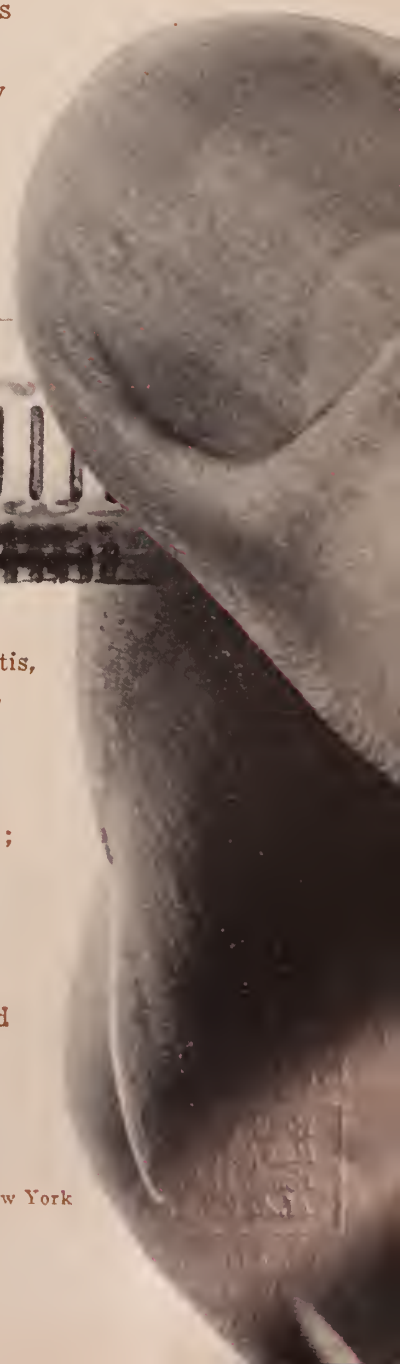
TRIAMCINOLONE

Diacetate Parenteral Suspension Lederle

highly effective repository action with single, or infrequent, I.M. injections

Single I.M. doses of ARISTOCORT FORTE 4 to 7 times the usual daily oral dose can control symptoms 4 to 7 days, or even longer—sometimes up to 4 weeks in responsive conditions. . . . Total amount of steroid required is often less than with oral forms. Thus, steroid side effects are minimized. Another advantage of ARISTOCORT FORTE: may be given through a small-gauge needle, causing the patient no discomfort . . . plus the special advantages of triamcinolone.





INDICATIONS: Asthma and other allergies, including allergic rhinitis, hay fever, drug reactions; dermatoses, including psoriasis, poison ivy, urticaria, atopic eczema, pruritus; rheumatoid arthritis and other musculoskeletal conditions.

ARISTOCORT FORTE Parenteral – a suspension of 40 mg./cc. of triamcinolone diacetate micronized in: polysorbate 80 USP . . . 0.20%; polyethylene glycol 4,000 USP . . . 3%; sodium chloride . . . 0.85%; benzyl alcohol . . . 0.90%; water for injection q.s. . . . 100%; hydrochloric acid to approx. pH 6.

Not For Intravenous Use

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle LEDERLE LABORATORIES
A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving actio

SOMA®

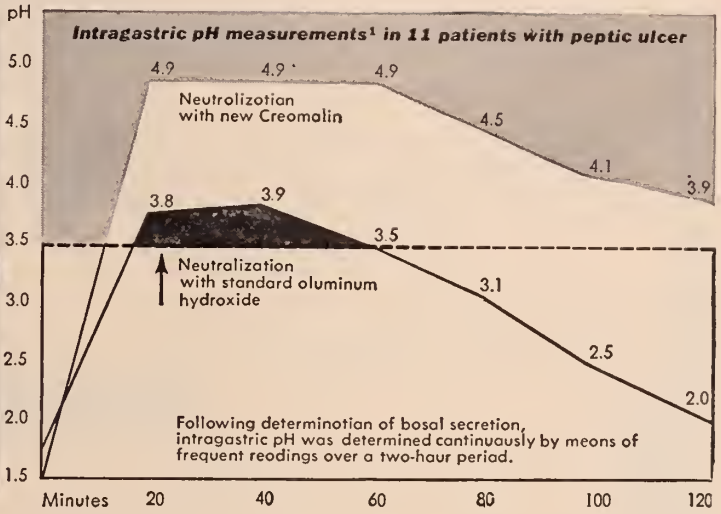
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Wallace Laboratories, Cranbury, New Jerse

Acts as well in people as in test tubes

in vivo
neutralizes
40 to 50 per cent
faster—
twice as long at
pH 3.5 or above





New Creamalin®

Antacid Tablets

Buffers fast[1-4] for fast relief of pain—
takes up more acid

Heals ulcer fast—action more prolonged *in vivo*

Has superior action of a liquid, with the convenience of a tablet[5]

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed.
Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours.

How Supplied: Creamalin Tablets, bottles of 50, 100, 200 and 1000.
Also available: New Creamalin Liquid (1 teaspoon=1 tablet), bottles of 8 and 16 fl. oz.

References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N.Y.

FOR PEPTIC ULCER • GASTRITIS • GASTRIC HYPERACIDITY

CONSISTENTLY SUCCESSFUL IN RELIEVING DRY, ITCHY SKIN

Sardo®

BATH OIL

STUDY 1 *Spoor, H. J.: N. Y. State J.M. 58:3292, 1958.*

satisfactory results in 88% of cases

comments: "In practically every instance... the patients experienced relief from dryness and pruritus."

STUDY 2 *Lubowe, I. I.: Western Med. 1:45, 1960.*

satisfactory results in 94% of cases

comments: Sardo "reduced inflammation, itching, irritation, and other discomfort..."

STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

satisfactory results in 91% of cases

comments: "Scaling disappeared, and... the skin became softer and smoother..." with Sardo.

INDICATIONS

- eczematoid dermatitis
- atopic dermatitis
- senile pruritus
- contact dermatitis
- nummular dermatitis
- neurodermatitis
- soap dermatitis
- ichthyosis*



SARDO IN THE BATH releases millions of microfine water-miscible globules* which act to (a) lubricate and soften skin, (b) replenish natural emollient oil, (c) prevent excessive evaporation of essential moisture.

Patients appreciate pleasant, convenient SARDO.
Non-sticky, non-sensitizing, economical. Bottles of 4, 8 and 16 oz.



for samples and literature, please write...

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OBESTAT Ty-Med*

A Single Tablet Daily for Obesity Control

The elinieal story of OBESTAT TY-MED is simplieity itself—

The formula:

Methamphetamine HCl	10 mg.	-	anorectic; mood improver
Amobarbital (WARNING: May be habit forming)	60 mg.	-	stabilizing agent
Thyroid	150 mg.	-	calorigenic agent

In TY-MED *form:*

A LEMMON-developed, improved "timed-release" eompounding proeess, providing smooth therapeutic response from breakfast to supper with a single daily morning dose.

Advantage:

OBESTAT TY-MED spares your patients the inconvenienee of taking smaller amounts of its therapeutie ingredients in three or four daily divided doses. Your "forgetful" patients are more apt to adhere to a single-dose sehedule, and prove more cooperative in following your dietary regimen and other measures.

Dosage:

Most patients will show satisfactory weight-loss and appetite control with a single tablet daily, taken upon arising. The occasional patient will require two tablets.

Important: It must be noted that 150 mg. of thyroid in its usual form, ingested and absorbed in a short period of time, could cause thyroid intoxication in many patients. However, as constituted in OBESTAT TY-MED, all three active ingredients are released gradually and uniformly over a 10-12 hour period.

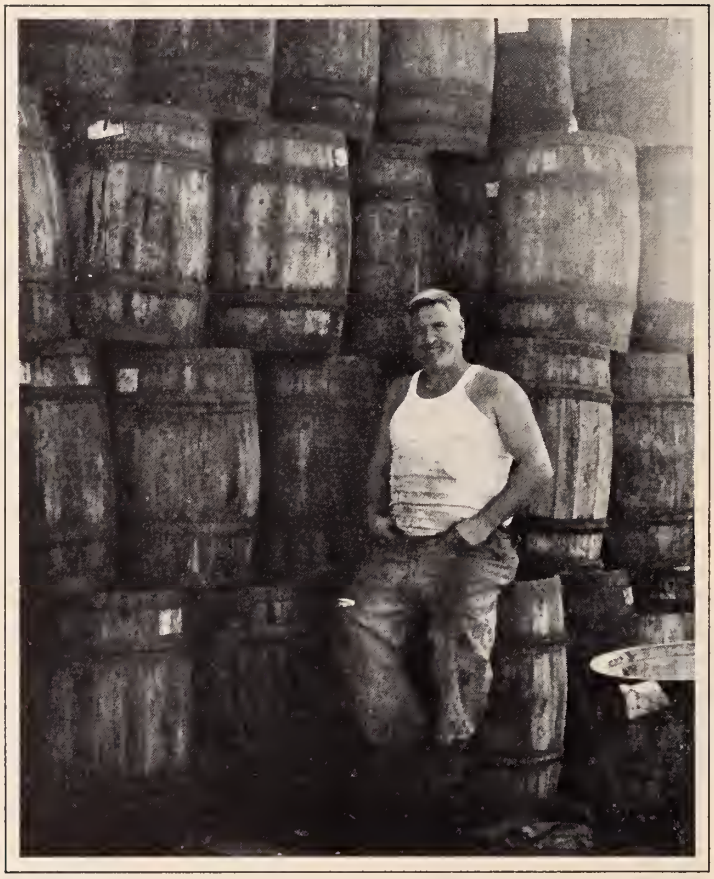
Caution: Federal law requires the customary warning that preparations containing any amphetamine or thyroid are contraindicated in cardiacs, hypertensives, diabetics or in hyperthyroidism.

Supplied: Bottles of 100 green and white tablets, on prescription only.

LEMMON Pharmacal Company

Sellersville, Pa.

Ethical specialties to the medical profession



He needs his muscles working properly—
when they aren't, he needs

Trancopal

How to use *Trancopal*®

Brand of chlormezanone

for painful muscles

When a muscle is strained, it goes into a spasm that produces pain; this is followed by more spasm for splinting, and then more pain.

When you prescribe Trancopal, you break this vicious cycle and relieve the patient's discomfort. Trancopal will ease the spasm and consequently the pain, and its mild tranquilizing effect will make the patient less restless. You can then start him on purposeful exercise or physical therapy.

In addition to its usefulness in syndromes resulting from overstraining (such as low back pain or tennis elbow), Trancopal will relax the spasm and pain that are features of torticollis, bursitis, fibrositis, myositis, ankle sprain, osteoarthritis, rheumatoid arthritis, disc syndrome and postoperative muscle spasm. Trancopal is available in 200 mg. Caplets® (green colored, scored) and in 100 mg. Caplets (peach colored, scored), bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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1626M



ANNOUNCING

CAPLA™

A new drug that works in a new way to control blood pressure without serious side effects

Capla acts centrally at the brainstem vasomotor center

Capla reduces blood pressure by acting predominantly at the brainstem vasomotor center; is not a ganglionic blocker. It produces no depression, no postural hypotension, no nasal congestion, no gastric hyperacidity. Transient drowsiness sometimes occurs, usually at higher dosage.

New therapy

Alone, Capla is highly effective for mild to moderate hypertension. In more severe cases, it can be combined with diuretics or peripherally acting antihypertensives.

Proved effective in clinical use

Capla reduces both systolic and diastolic pressure usually in proportion to pre-therapy levels. Patients on Capla often report a mild calming effect. Capla has proved exceptionally well tolerated in clinical use and has no known contraindications.

RECOMMENDED DOSAGE: one tablet 3 or 4 times daily, before meals and at bedtime. Dosage should be adjusted to individual requirements.
COMPOSITION: each white, scored tablet, contains 300 mg. of Capla (mebutamate, Wallace).
SUPPLIED: bottles of 100 tablets.

Literature and samples to physicians on request.

CAPLA™

Central Acting Pressure Lowering Agent

Wallace Laboratories, Cranbury, New Jersey

CLINICAL & PHARMACOLOGICAL REPORTS 1. Berger, F. M., and Margolin, S.: A Centrally Acting Blood Pressure Lowering Agent (W-583). Fed. Proc. *20*:113 (March) 1961. 2. Diamond, S., and Schwartz, M. Scientific Exhibit at Ill. State Med. Soc. Chicago, (May) 1961. 3. Douglas, J. F. Ludwig, B. J., Ginsberg, T. and Berger, F. M.: Studies on W-583 Metabolism. Fed. Proc. *20*:113 (March) 1961. 4. Duarte, C., Brest, A. N., Kodama, R., Naso, F., and Moyer, J. H.: Observations on the Antihypertensive Effectiveness of a New Propanediol Dicarbamate (W-583). Curr. Ther. Res., *2*:148-52 (May) 1960. 5. DuChez, J. W., Scientific Exhibit at Amer. Academy of Gen. Practice, Miami, (April) 1961. 6. Kletzkin, M., and Berger, F. M.: A Centrally Acting Antipressor Agent. Fed. Prod. *20*:113 (March) 1961. 7. Mulinos, M. G., Scientific Exhibit at Amer. Coll. Card. New York, (May) 1961. 8. Mulinos, M. G., Saltefors, S., Boyd, L. J. and Cronk, G. A.: Human Pharmacology Studies with W-583. Fed. Proc. *20*:113 (March) 1961. 9. Shubin, H., Scientific Exhibit, Amer. Coll. Card. New York, (May) 1961.

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PEDIATRIC VITAMINS
PLUS SODIUM FLUORIDE

provide
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nutritional
support
plus
prophylaxis
against
future
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PEDIATRIC DROPS

Each 0.6 ml. provides, 400 U.S.P. units vitamin D, 30 mg. vitamin C and 0.5 mg. fluorine (as sodium fluoride). *Available in 30 ml. and 50 ml. bottles with calibrated droppers.*

MULTIPLE VITAMINS PLUS SODIUM FLUORIDE

Quanti-Vite™ (F)

PEDIATRIC DROPS

Each 0.6 ml. provides, 3,000 U.S.P. units vitamin A, 400 U.S.P. units vitamin D, 60 mg. vitamin C, 1 mg. vitamin B_1, 1.2 mg. vitamin B_2, 1 mg. vitamin B_6, 10 mg. niacinamide and 0.5 mg. fluorine (as sodium fluoride). *Available in 50 ml. bottles with calibrated droppers.*

* Daily administrations of Funda-Vite(F) or Quanti-Vite(F) should be consistent and continuous if substantial dental benefits are to be anticipated.

AVAILABLE ON PRESCRIPTION ONLY
CONTRAINDICATED IN COMMUNITIES WITH FLUORIDATED DRINKING WATER.

HOYT

SAMPLES AND LITERATURE — Write Medical Department
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PIONEERS IN PEDIATRIC VITAMIN-FLUORIDE SUPPLEMENTS



vertigo is reversible



Antivert® stops vertigo

moderate to complete relief of symptoms in 9 out of 10 patients[1]

Prescribe one ANTIVERT tablet (or 1-2 teaspoonfuls ANTIVERT syrup) 3 times daily, before each meal, for prompt relief of vertigo, Meniere's syndrome and allied disorders. Side effects are short-lived, usually only harmless flushing and tingling associated with vasodilation. As with all vasodilators, ANTIVERT is contraindicated in severe hypotension and hemorrhage.

Supplied: Small blue-and-white scored tablets (meclizine HCl 12.5 mg. and nicotinic acid 50 mg.) in bottles of 100. Syrup (each 5 cc. teaspoonful contains meclizine HCl 6.25 mg. and nicotinic acid 25 mg.) in pint bottles. Prescription only. Bibliography available on request.

Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. 38:738 (Sept.) 1959.

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five-factor geriatric supplement

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So small it fits in the smallest briefcase with plenty of room left over! Wonderful for office, school or home, perfect as a gift that keeps on giving! Only 4½ pounds, 8" x 8" x 2½". Battery powered. Push Button controls. Two constant speeds, dual track; records and plays back one full hour on a 3" reel of tape. With mike, batteries and carrying strap. Gift Boxed.

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INCORPORATED

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Dear Doctor:

Reports from our representatives indicate that many physicians would appreciate simplification for prescription-writing purposes of the names of Terramycin products in both the "plain" and the "Cosa" dosage forms.

The "Cosa" forms originated, you may recall, on the basis of clinical evidence of enhanced antibiotic absorption when glucosamine is employed in oral administration. To permit each physician individually to study this evidence and choose which form he would prefer to prescribe, we offered Terramycin in both forms—that is, in the regular Terramycin forms without glucosamine, and in the "Cosa" forms with glucosamine.

This distinction appears to be no longer necessary since glucosamine, a highly acceptable excipient for oral antibiotics, now is being incorporated uniformly in all such forms, thereby simplifying nomenclature and your prescription writing.

Accordingly, and effective immediately, forms incorporating glucosamine will be offered simply as Terramycin without the "Cosa" prefix.

To make clear just which forms are affected, please refer to the brief tabulation (below) of Terramycin dosage forms both *before* and *after* this change. We are also requesting our representative to call on you at an early date to answer any questions that may arise.

We feel certain that this action, prompted by your comments and those of many other physicians, will simplify your writing of prescriptions for Terramycin products.

We welcome your comments on this action and on any other phase of our operations, since it is our objective to render every service as efficiently as possible to our friends in the medical profession.

Sincerely,
PFIZER LABORATORIES

The following table indicates the former name and the current name of Terramycin systemic preparations:

FORMERLY NAMED	NOW NAMED
Cosa-Terramycin® Capsules	**Terramycin**® Capsules*
Cosa-Terrabon® Oral Suspension	**Terramycin** Syrup
Cosa-Terrabon Pediatric Drops	**Terramycin** Pediatric Drops

and simpler names for these Terramycin-containing formulations:

Cosa-Terrastatin® Capsules	**Terrastatin**® Capsules
Cosa-Terrastatin for Oral Suspension	**Terrastatin** for Oral Suspension
Cosa-Terracydin® Capsules	**Terracydin**® Capsules

. . . and these names remain unchanged:

Terramycin Intramuscular Solution
Terramycin Intravenous

**Terramycin Capsules* without glucosamine *are no longer available.*

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser W., and Fong T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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SAPERSTEIN, R. B.: Treatment of Acne with Long Term Continuous Abrasion. A.M.A. Archives of Derm. 81: 601, April 1960.

REES, R. B.; BENNETT, J. H.; GREENLEE, M. R.: Newer Drug Treatment in Dermatology, Cal. Med., 91:1, July 1959.

SULZBERGER, M. B. & WITTEN, V. H.: The Management of Acne Today. Med. Clinics of No. America, 43:3, May 1959.

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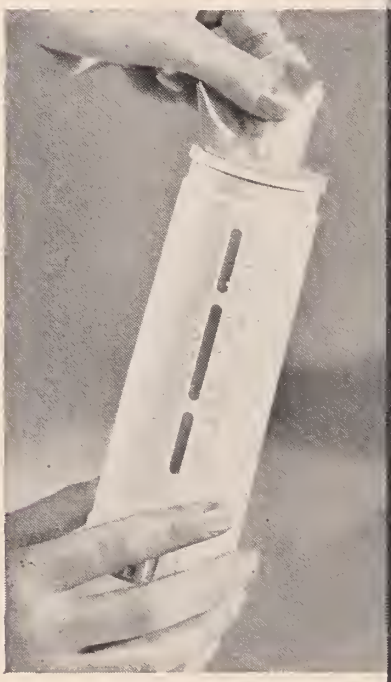
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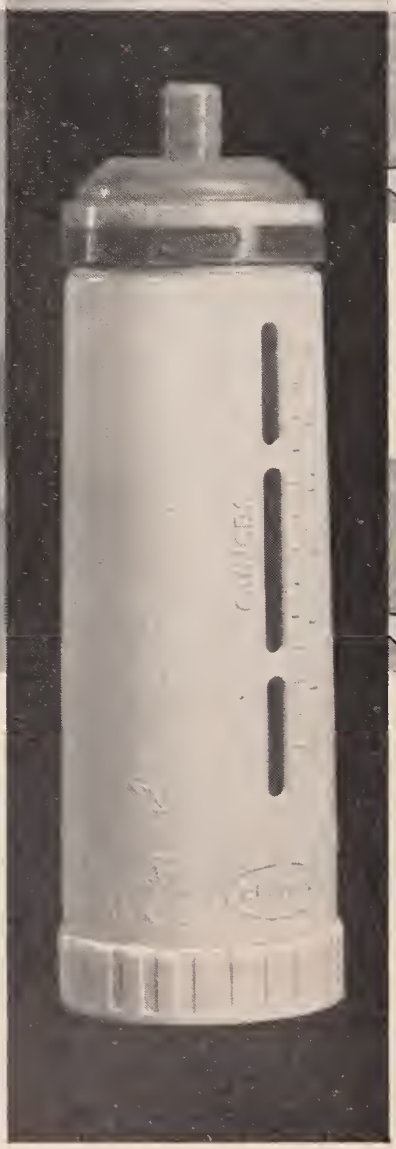
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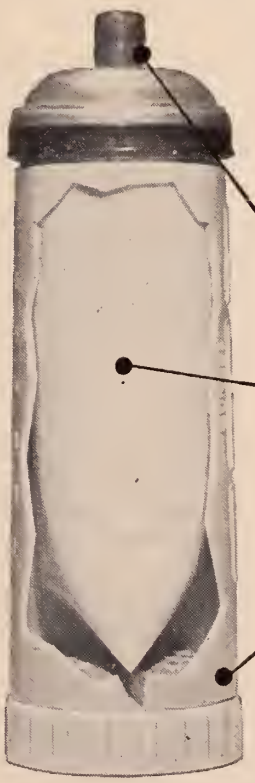
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How much money would be saved if all prescriptions were written for generic-name drugs?

"The [Rhode Island] Division of Public Assistance examined 10,000 drug prescriptions for welfare recipients for the purpose of determining the actual savings . . . of generic versus trade-name drugs. The drugs had cost $28,000. Substituting generic drugs whenever possible would have provided a saving of less than 5 per cent. Syracuse has made a similar study of drug costs with comparable results."

Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

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*Gant, J. Q., Jr.: *M. Ann. District of Columbia 30*:267, 1961.

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Editorials • • •

Medicine's Positive Program

The imminent Congressional battle over a proposal to provide hospital and nursing care for the aged through Social Security poses an urgent challenge to the medical profession. It is a challenge to deliver a solid, realistic program of prepaid medical care for the people of the United States through its own voluntary mechanisms, *or* to have such a program imposed upon us. To ignore this may be to forfeit our last opportunity to preserve private enterprise in medical practice. And it would be naive to suppose that organized medicine and its allies can decisively turn back the tide without offering a preferable substitute program.

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Blue Shield has a formula for providing medical services on terms that have proved satisfactory both to the patient and the doctor. If all Blue Shield Plans were offering as good a program as the best of them do today, private medicine could meet the challenge of the immediate future with reasonable confidence in the public decision.

Blue Shield can do as good a job as we doctors will *permit* it to do—and it can do as good a job as we *demand* that it do. But in many areas of this land, we physicians must lift the heavy hand of suspicion and restraint from our Blue Shield Plans, and offer these Plans of ours a bold and helping hand of confidence and leadership. There may be other ways of saving free medicine—but Blue Shield lies close at hand—and ready.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 685

VOL. 58, NO. 9 SEPTEMBER, 1961 Subscriptions, $3.00 per year
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The Best of All Possible Drugs

A bill recently introduced in the Congress would ban the patenting of a new drug unless the manufacturer could prove that it was significantly more effective than all similar drugs now available. This well intended, if somewhat naive proposal is an interesting example of how the plausible can become the mischievous. If the bill passes, Government will somehow determine the relative efficacy of each new drug. Similar criteria, one might suppose, would be applied to cigarets, automobiles, television sets and cocktails. Let us permit only the best pencils, pickles, or penicillin to be sold.

Only an amateur would suppose that drug efficacy can be determined that simply. If a drug is potent, it is also potentially dangerous. At what point does the danger outweigh the benefit? How does the federal agency allow for personal idiosyncracy of patients? Is a pleasantly flavored vehicle enough to warrant a patent if there is no change in pharmacologic effectiveness? How do you appraise therapeutic efficiency in human beings without trying the drug before it is made available for human use? Do you release it on the basis of animal experiments only? How does a Government tribunal weigh the placebo effect, the suggestive effect, and effect of the practitioner's art on the workings of a new pharmaceutical?

Of course the Federal Government can, by a simple act of Congress create a Section for the Appraisal of Pharmaceuticals (to be identified by its capital initials), and thus the Voice of Authority will tell us what is good for us. The Voice of Authority once rejected Lister's theory of antisepsis, Jenner's vaccination against small pox, Semmelweiss's report on the cause of puerperal fever—not to mention Auenbrugger's discovery of the value of chest percussion. Federal appraisal of drug efficiency offers a road well paved with good intentions—and fraught with the mischief that often comes when amateurs make technical decisions for the professionally trained.

Seat Belts and Common Sense

Agreement by automobile manufacturers to provide built-in attachment points for seat belts in 1962 cars is a welcome step in auto safety. It will provide a strong impetus to public acceptance of seat belts. This achievement can be credited to the persuasive efforts of the U.S. Public Health Service, the American Medical Association, National Safety Council, the American College of Surgeons, and other organizations concerned with traffic safety. Consumers Union has been supporting the use of seat belts (and testing them) for several years.

Despite the appropriateness of this development, there is a possibility that it may backfire and eventually damage the cause of seat belts and of other safety measures. To avoid this contingency, it behooves the proponents of seat belts to take a sober look ahead, to recognize and pass along to the public some realistic perspectives on the matter. These include:

(1) The benefits to be derived from the installation of belt attachment points are entirely dependent on the public's cooperation in buying and using seat belts.

(2) The scientifically established facts* about the effect of seat belts in controlling

*Automotive Crash Injury Research of Cornell University is the only group in the U.S. to have collected and analyzed massive statistical data on actual accidents involving seat belts. The pertinent studies are: *Safety Belt Effectiveness in Rural California Automobile Accidents*, by B. Tourin and J. W. Garrett, Feb., 1960, and *Ejection and Automobile Fatalities*, by B. Tourin, May, 1958. Earlier reports from the same Cornell group, furnished in Congressional testimony in 1956 and 1957, made more optimistic estimation of seat belt effectiveness.

death and injury are: belt users are just as likely to be hurt in accidents as non-users; but belt users are likely to sustain injuries of a less severe nature; in comparable accidents, belt users experience about 35 per cent fewer serious injuries than non-users; there are no conclusive data with respect to fatalities—but carefully qualified predictions based on large-scale studies *suggest* a reduction in fatalities of 25 to 50 per cent.

(3) Even though the *individual* using a seat belt can reduce his own risk of severe injury by about 35 per cent and might reduce his own risk of death by anywhere from 25 to 50 per cent, the *national* highway fatality toll would reflect this much reduction *only* if *all* cars, old and new, have seat belts for *all* passengers, and the belts are used.

(4) It follows that even if all 1962 cars (but only 1962 cars) were to be equipped by their owners with belts for the anchors provided, and if 1962 cars were to be 10 per cent of the cars on the road in 1962, the overall reduction of severe injuries could be no more than 3 per cent. The overall reduction of deaths would be likely to be no more than about 5 per cent. We cannot expect even as much as a 5 per cent improvement in the overall picture from the seat belt attachment points in the 1962 cars.

The public has been blithely led to expect that the seat belt anchors will lead to a reduction of injuries and/or deaths by as much as 60 per cent. We must consider that disillusionment with seat belts may result in 1963, if the 60 per cent turns out to be in the order of 3 per cent. Public acceptance of seat belts, and of other safety measures, may thereby be set back severely.

It is, therefore, imperative that all responsible organizations intensify their efforts to persuade the public to install seat belts in *all* cars and to use them. And we must demonstrate to the public any real improvement resulting from their use of seat belts. Since the improvement at first may be masked by other changes operating in the automotive safety field, it will be necessary to conduct careful studies during this crucial period. We suggest that steps be taken before 1962 to lay the groundwork for valid studies.

Highway patrols and state motor vehicle bureaus should be encouraged to collect data on the presence and use of seat belts in cars (*at least* those involved in accidents). Reports on the severity of injuries should be obtained.

For several years experts have estimated that seat belts may reduce fatalities by 50 per cent, but furnished no supporting statistical evidence. Cornell, in 1960, showed a 50 per cent reduction of fatality among a massive sample of seat belt wearers in accidents —but cautioned that the fatality data on which this figure was based were *too sparse for statistical significance* (among the 10,000 automobile occupants studied there were only 65 deaths, of both users and non-users of belts).

Over-enthusiastic supporters of seat belts have seized this 50 per cent estimate and applied it to the 38,000 deaths seen annually. Thus they concluded that a saving of 19,000 lives is possible. Furthermore, they failed to take into account that some 16,000 of the 38,-000 fatalities are pedestrians, bicyclists, and occupants of trucks and buses.

One reason for the sparseness of data in the past has been that too few people have had seat belts to make a detailed study feasible. This situation makes it incumbent on safety-minded organizations to promote (1) the accumulation of more data at a time when more people will be using belts, and (2) the statistical study of the data, lest the general public suffers an unwarranted disillusionment.

Other passenger protective features—such as built-in crash paddings, better door locks, and recessed hub steering wheels—should not be neglected during the period of upsurge in public interest in seat belts.

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Teaneck

The Cardiac Patient and Surgery:*

An Integrated Approach

Offered here is a step-by-step blue-print, almost a check list, for surgery in the cardiac patient. Such a survey is troublesome and time-taking: but may be life-saving.

More people than ever before are reaching advanced years. These patients are subject (increasingly with their years) to the hazards of cardiovascular disease and surgery. Frequently both of these occur in the same person. The impaired cardiac status may not be recognized prior to surgery.

It is of great concern to us to unmask presymptomatic heart disease.[1] This can be done in almost every instance. I here offer a concise and integrated approach which should make this practical. The following factors should be considered prior to surgery.

THE PATIENT

The patient who does not appear to be a "cardiac" should be conscientiously scrutinized for the less obvious evidences of heart disease. It is less important to make an accurate anatomic diagnosis than it is to make an accurate appraisal of his functional capacity, especially under stress. Here are some of the questions to be answered:

(1) Have there been any angina attacks? How frequent? Is the frequency increasing? It may be necessary to advise an operation quickly before it is too late.

(2) Is there a history of coronary episodes? If so, how many attacks? When was the last one? What was the estimate of heart damage? What residua are there?

(3) Is there evidence of significantly diminished cardiac reserve?

(4) Is there any co-existing vascular, emotional, nephropathic or metabolic disease?

(5) Have there been episodes of frank congestive failure?

(6) Are there evidences of cryptic or latent congestive failure?

(7) Has the cardiac disease led to any substantial nutritional or electrolyte disturbance?

(8) How necessary is the operation?

Of these eight factors, the prime stumbling block is failure to elicit evidences of cryptic congestive failure. To avoid this, inquiry should be directed to the following:

a. Unexplained night cough;
b. Easy fatigue;
c. Swelling anywhere, especially at night;
d. Wide fluctuations of weight without apparent cause;
e. Failure of small cuts and wounds (especially on the lower extremities) to heal rapidly. Care should be taken to exclude diabetes or other "constitutional" disease.
f. Gradual curtailment of previous activities.

Physical examination obviously will include height, weight, general physical make-up, ex-

* This paper is based on an address given before the Clinical Society of the North Hudson Hospital, Weehawken, N. J., on December 14, 1960.

1. A. P. Fishman: Personal communication to the author.

amination of the heart, blood pressure, pulse rate and rhythm and lungs. Other evidences of cardiac disease must be sought in the skin, mucous membranes, extremities and liver. At this point, the clinician should review the nature of the surgical disease. We must be sure that it is not a manifestation of the cardiac or other medical condition. For example, a rheumatic myopathy involving the abdominal muscle; or epigastric distress from a coronary episode simulating a peptic ulcer; or distension from anoxia appearing like an intestinal obstruction.

LABORATORY TESTS

THE three basic tests are urine analysis, blood count and blood chemistry. The last should include at least sugar, blood urea nitrogen and cholesterol. In special cases (such as in those who have been on long term anti-coagulant therapy) bleeding time, coagulation time and prothrombin time determinations are called for. Electrocardiography, especially in arrhythmias, is desirable.

FUNCTION TESTS

INQUIRY should be made into the following:

1. How long can patient hold breath? At least 15 seconds is the desired norm.
2. How long does it take for pulse rate to return to normal after exercise? The desirable maximum is two minutes.
3. How much weight gain is there after a measured amount of salt and water ingestion; and how long does it take to return to the prior weight, if at all?
4. Can he blow out a match at 15 inches?
5. Any other test appropriate to the case, such as ballistocardiography or spirometry.

THE OPERATION

SURGERY is obligatory if the surgical disease produces the cardiac disease, such as in hyperthyroidism, cardiac tamponade from blood or other fluid, or pheochromocytoma.

Surgery is generally necessary when the surgical disease is co-existent with and parallel to the cardiac disease. For example, enlargement of the prostate and hypertensive heart disease are both part of advancing age.[2] If a prostatic enlargement is allowed to produce an obstructive nephropathy, then the cardiovascular status will be adversely affected. In these cases, *delayed surgery may be fatal surgery*. In this situation, delay may be tolerated only if it is designed to improve the patient's condition and thus his chances of survival.

Surgery may be necessary if the surgical condition is one in which chance of a cure by spontaneous regression is almost hopeless, as in malignant conditions or abdominal aneurysm. In this group some thoughtful clinicians include such conditions as asymptomatic cholelithiasis. Angina pectoris is now considered by many to be in this class.[3]

In the less "obligatory" cases, the known risks must be weighed against the possible benefits. Natural longevity for an age group must be carefully weighed, especially the life expectancy of a cardiac patient. The severity and frequency of the symptoms, and the ease or difficulty of relieving these, are to be considered. Factors peculiar to each case must be carefully weighed. When the decision to operate is reached, the patient must be properly prepared.

PREPARATION OF THE PATIENT

CONGESTIVE heart failure must be treated promptly and energetically. The program includes:

(1) Digitalization—parenterally by rapid acting preparations;

(2) Relief of peripheral edema by diuretics, and digitalis;

(3) Restoration of normal rhythm by digitalis, Quinidine and suitable electrolytes[4] if necessary.

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2. Wilkins, I.: Journal of Urology, 13:37 (1925).

3. Thompson, S. and Plachta, A.: Journal of the American Med. Assn., 152:678 (1953); Beck, C. S.: Annals of Surgery, 102:901 (1935); and J. of Thoracic Surgery, 102:90 (1936).

4. Sampson, J. J., *et al.*: American Heart Journal, 26:164 (1943).

(4) Administration of fluids to combat dehydration, shock and electrolyte imbalance if present;

(5) Narcotics if necessary where pain contributes to shock;

(6) Restoration of normal blood coagulation where the patient is on anti-coagulants.

If there is enough time, then all the usual measures can be carried out with greater deliberation. These include:

(a) Digitalization by oral route is preferred. Signs of digitalis-induced arrhythmia or toxicity are looked for and corrected.

(b) Diuretics if necessary for edema and the reduction of hypervolemia. Pre-operatively, extreme caution is needed in the use of potent oral diuretics.[5] It should be checked with electrolyte studies. In the presence of ectopic beats, diuretics should be used with conservatism or not at all until the practitioner is sure that these beats are not digitalis-induced.

(c) Arrhythmias from any cause should be detected and corrected, if it is at all possible. Pre-existing arrhythmias, especially ectopic beats, can be conducive to ventricular fibrillation and/or cardiac standstill.

(d) Antihypertensive drugs should be discontinued as soon as possible *before* the operation, or at least markedly reduced. Reserpine can predispose to hypotension under anesthesia,[6] and enhances some toxic effects of digitalis.[7]

(e) Nutritional status must be at its optimum, consistent with the conditions encountered. This should include electrolyte balance. An imbalance here may have an important bearing on arrhythmia and digitalization. Potassium can abolish digitalis-induced arrhythmias without affecting its cardiotonic properties.[8]

(f) The patient should arrive for surgery in the best mental condition. Sedatives and tranquilizers, although useful, are no substitute for the confidence instilled by a kind, sympathetic, but authoritative physician. The anesthetist can also have a beneficial effect by his presence and indicating that he has full command of the situation. Pre-operative sedation must be used with caution, so as not to suppress vital functions, especially respiration.

THE OPERATION

THE anesthetist should have full command of the technics, agents and other details. He will try to avoid gagging, coughing or rise in intra-abdominal pressure, which in turn may give rise to the Valsalva maneuver. The cardiac patient is more susceptible to surgical hazards such as hemorrhage, shock, thrombosis, embolism and electrolyte disturbances than the normal patient. Blood loss must be adequately and promptly replaced. Shock must be prevented or relieved as soon as possible. Some anesthetic drugs and procedures (particularly spinal and intravenous anesthesia) may produce hypotension more readily than others.[9] Do not overhydrate. This may cause failure from hypervolemia. Surgical trauma can produce electrolyte tissue shifts[10] and a previously well digitalized patient may show extrasystoles. Bank blood may have potassium leakage from erythrocytes into the serum, producing an elevated potassium content. Red blood cells are affected by digitalis, producing high sodium and low potassium blood levels.[11] Due to shock, hypotension and/or hemorrhage, the coronary patient is more susceptible to acute massive infarction.[12] Muscle relaxants and paralyzants may inhibit the diaphragm enough to impair seriously, venous return, leading to anoxia.[13] Arrhythmias are reported[14] to be controlled by intravenous injection of about 50 milligrams of procaine and magnesium.[15] Shock, unexplained by hemorrhage or surgical trauma, may be indicative of acute myocardial infarction which should be recognized as soon as possible. It is no disgrace to terminate an operation if feasible in the presence of suspected myocardial infarction or other cardiac catastrophe.[16]

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5. Lown, A., Black, B. and Moore, C.: American Journal of Cardiology, 7:2 (1960).

6. Coakley, C. S. *et al.*: Journal of the American Med. Assn., 161:1143 (1956).

7. Lown, A., Black, B. and Moore, C.: Citation 5 above; page 32.

8. Lown, A., *et al.*: Journal of Clinical Investigation, 31:684 (1952).

9. Collins, V. J.: Bulletin of the N. Y. Academy of Medicine, 31:438 (1955).

10. Moore, F. D.: New England J. of Medicine, 258:277; and 325:177 (1958); Wilson, A. M., *et al.*: Circulation, 9:199 (1954); and Moore, I. and Ball, V.: Metabolic Response to Surgery, Thomas, 1954, Springfield, Ill.

11. Lown, A., *et al.*: Citation 8 above, pages 99 through 103.

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13. Beecher, V. and Todd, W.: Annals of Surgery, 140:1 (1914).

14. Burstein, G.: Anesthesiology, 7:113 (1946).

15. Szekely, P.: British Heart J., 8:115 (1946); Engelbey, C., *et al.*: American Heart J., 39:703 (1950); and Szekely, P. and Wynne, Ed.: Clinical Science, 10:241 (1951).

POSTOPERATIVE CARE

THE cardiac is unduly susceptible to the usual surgical hazards. In spite of this, properly prepared and managed cardiac patients withstand surgery remarkably well.[17] Adequate hydration is essential, with care taken not to overhydrate. Electrolyte balance must be checked. Here the electrocardiogram can be most useful, especially in potassium determinations.[18] Adequate digitalization and diuresis, if indicated are just as vital now as before. Do not overdigitalize as this may produce sinus tachycardia.[19] Sudden onset of ventricular tachycardia may be due to myocardial infarction. *Digitalis must be avoided.* Quinidine and procaine amide must be used instead.[20] Pain can initiate its own non-specific shock and must be controlled. Operative hypoxia and/or postoperative increase in fibrinogen and platelets can produce myocardial infarction.[21] Early ambulation may have to be postponed. Here the decision is individualized, according to the circumstances. Adequate nutrition must not be neglected. Foods must be concentrated, and contain sufficient vitamins and minerals. One form of cryptic congestive failure that can be easily overlooked is failure of the wound to heal. To be sure unabsorbed sutures, and other factors easily attributable to surgical causes may be found. But if any degree of peripheral edema of the operative area, due to congestive heart failure is present, one or both of two mechanisms may be present. First is interference with cellular nutrition due to stasis with failure to heal; second, the wound cavity, particularly the deep subcutaneous tissues, may act as a sump. The discharge may appear to be interminable and may even look purulent. In any case, where congestive failure may be a factor, this aspect should not be overlooked. Thinking of it will frequently initiate a search which will uncover other stigmata.

SUMMARY

THE patient, his surgical disease, his pre-existing cardiovascular status and his milieu are functions of each other and must be considered as a whole. However, any particular factor may be so overwhelming as to dominate the clinical picture. The various factors are presented and discussed in an attempt to provide an integrated approach. A concise methodology is offered for the consideration of all practitioners who have to meet this growing problem.

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Drug Addicts Look Normal

How do you recognize a drug addict? Not very easily, according to *Patterns of Disease,* a Parke, Davis & Company publication for the medical profession. "Because addicts appear normal physically and mentally, their detection is difficult" *Patterns* says. Pupillary constriction is one warning signal—but only with addicts who have not developed tolerance to drugs. Other signs to look for are needle marks, scars and abscesses and tattoo marks, often used by addicts to cover needle marks. The most definitive symptom of all, though, is "development of the characteristic withdrawal syndrome." Among the most common withdrawal symptoms are weakness, restlessness, appetite loss, leg pain, back pain and vomiting.

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Intrascrotal Non-Testicular Tumors

Not all tumors of the scrotal contents entrap testicular tissue. But all such growths should be swiftly biopsied.

Scrotal content lesions are varied and often present a difficult, but interesting diagnostic problem. To divide these growths into benign and malignant is of little value. Many "benign" lesions have undergone malignant changes. There are ambiguities when one attempts to categorize them. Diagnosis, treatment and prognosis are often contradictory due to the lack of adequate case identification and classification. Reviews and reports reflect this confusion, from Patel Chalier,[1] who collected 110 cases in foreign literature, and the early papers by Hinman and Gibson,[2] (1924) and Thompson's excellent clinical treatise[3] in 1936.

A survey by Satter[4] revealed over 200 cases of such tumors. Tumors of spermatic cord and testicular tumors were three times more frequent than those in the epididymis. Many tumors of the epididymis reported as carcinoma would very probably be reclassified as adenomatoid today.[5] In the epididymis, half of the neoplasms are either fibrosarcoma or sarcoma. Interestingly, the same ratio applies in tumors of the spermatic cord. The remaining cases comprise mainly seminomas, teratomas and mixed cell carcinomas. No reviewed paper reported carcinoma in the spermatic cord.

Metastatic tumors from extra genito-urinary sources to the spermatic cord, testicular tunics or epididymis are rare. In one case, Rolnick[6] suggested a polyorchid testis as possible source since no tumors were found to originate from a supernumerary testis.

We propose here to report a case of fibromyosarcoma, which offered a challenge because of its bizarre history and physical appearance. It adds to the literature a possibly "cured" case.

A 48-year old, white "feeble-minded" male, on admission, July 1960, presented a heavy, huge, painless mass, in the left scrotum, of several months' duration. The remaining history was understandably unreliable, except that we knew that the mass grew slowly and never caused him pain or loss of weight. There were no other urologic complaints. The remaining systems were within normal limits. He had a large, hard, painless, irregular mass in the scrotum the size of a football. The left testicle could not be delineated nor the mass transilluminated. The skin was partially adherent to the mass. The right scrotal contents were within their normal limits. (See figure 1)

X-rays of the chest, intravenous pyelograms, urine and serology were all normal.

At operation, the entire mass was excised after high ligation of the cord at the internal ring. (See figure 2)

1. Patel, M. and Chalier, D.: Revue de Chirurgie (Paris), 39:119: 137, 354, 603, 792, and 942; 40:167 and 306 (all in 1909).
2. Hinman, F. and Gibson, T. E.: Archives of Surgery, 8:100 (1924).
3. Thompson, G. J.: Surgery, Gynecology and Obstetrics, 62:712 (1936).
4. Satter, A., Heidner, B. and Wear, C.: Journal of Urology, 82:48 (1959).
5. Hinman, F. and Gibson, T. E.: Archives of Surgery, 8:100 (1924).
6. Rolnick, D.: Journal of Urology, 85:316 (March 1961).



Figure 1.



Figure 2.

Pathologist's report: The aggregate measures 16 by 14 by 10 centimeters. The principal specimen consists of testicle which measures 45 by 30 millimeters surrounded by hydrocele containing clear straw colored fluid. Section of testicle reveals no gross pathological changes. Arising from the posterior-superior pole is a firm, thick mass —11.5 by 4.5 centimeters. Attached to the posterior part. mass is a fungus-like, gray-yellow, light brown mass. On section, it is yellow-gray, with scattered colors of pink. It is covered with minimal to moderate mucinous-like material. The portion of the tumor adjacent to the testes on section presents a trabeculated appearance separating the tumor tissue which is white-yellow-gray in color. The normal morphology is distorted, and in places, obliterated, which makes recognition difficult.

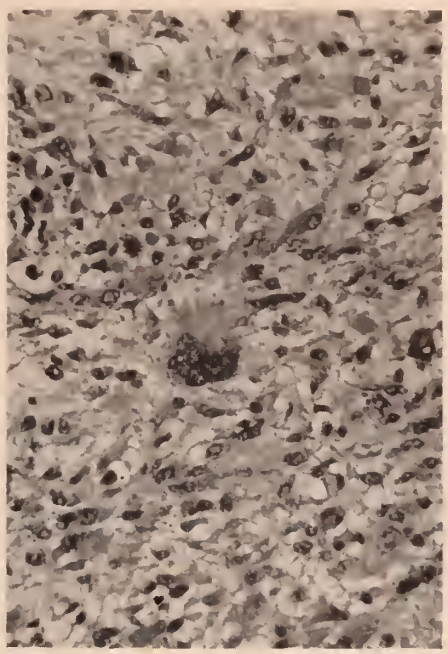


Figure 3.

Microscopically, the primary pathological process is one of the neoplasia. A portion of the section is composed of an abundant and dense fibrous tissue. Within it are numerous tumor cells that show marked anisocytosis and poikilocytosis. Their nuclei exhibit striking variation in size and shape with varying degrees of hyperchromatism. Many contain a distinct nucleolus. Mitotic figures are rare. Within this fibrous stroma, a mild lymphocytic infiltration is seen. One large area is composed of cellular myxomatous tissue. The cells vary markedly in size and shape and possess several cytoplasmic processes which join with those of the adjacent cells. Many of the cells are multinucleated. The nuclei vary markedly in size and shape and possess a moderate to marked hyperchromatism. Occasional mitotic figures are seen. Further sections reveal partial atrophy of the seminiferous tubules. Groups of interstitial cells are scattered through the intertubular stroma. There is no evidence of malignancy. The vessels are free and clear. Sections of epididymis are free of malignancy. (See figure 3)

Pathologic Diagnosis:

1. Chronic orchitis—non-specific.
2. Moderate atrophy of seminiferous tubules.



Figure 4.



Figure 5.

3. Chronic epididymitis—non-specific.
4. Fibromyxosarcoma of spermatic cord—left.

Postoperative course was uneventful. On discharge, he was advised to return for deep therapy. He did not return until November 1960, when he presented a pear-sized, hard, painless mass in the left scrotum. The rest of the physical examination was unchanged from the previous admission. Again there was no evidence of extension into the abdomen. (See figure 4)

At operation, the mass was removed with the overlying scrotum *en bloc*. (See figure 5) The pathologist's report follows:

The mass measures 9 by 13 centimeters and is partly covered by epidermis. On section, the tumor tissue is arranged in large nodular masses with bands of connective tissue coursing through the mass. A portion of the mass is undergoing degeneration which is gray-yellow and gelatinous. The wall is irregular.

The chief pathologic process is found microscopically to be that of anaplasia. The section is completely infiltrated by anaplastic cells varying in size and shape. There are large giant cells with multiple nuclei surrounded by abundant cytoplasm which possesses protoplastic processes. The nuclei like the cells, vary in size and shape and are markedly hyperchromatic. Some of the nuclei possess scanty cytoplasm and prominent nucleoli. There are several atypical mitotic figures. The tumor appears highly cellular with mostly elongated cells and scanty loose collagen stroma showing areas of myxomatous degeneration.

Pathologic Diagnosis: Recurrent fibromyxosarcoma. (See figure 5) The postoperative course was uneventful. The wound healed by second intention. This asymptomatic patient was discharged to Radiation Therapy and to the out-patient clinic where the plan shown below was instituted.

No recurrence has been noted to date.* No untoward symptoms are repeated by the patient. It is too early to evaluate the prognosis.

This case of intrascrotal non-testicular fibromyxosarcoma affords a "problem case" to re-emphasize the fact that malignant tumors of the spermatic cord, testicular tunics and epididymis are more common than previously recognized. The diagnosis is challenging and is to be suspected in an unidentifiable mass, especially when there is a painless, freely growing, rapid enlargement.

Concomitant hydrocele, epididymitis, hernia or torsion, may prove disarming.[7] Neither transillumination nor size offer a differential

FILTER

X-ray Generator	Kv.	Cu.	Al	HVL	MA	TSD-cm.	4/min. Air	Fields Daily	Interval
Constant	200	.5	1	1.3	15	50	556	2	x 5

EXPOSURE FACTORS (Field Size: 4 x 8)

Supra L. Pubis—12 exposures. 300 r. to skin daily to a total of 3600 r. Per cent depth dose was 366. Tumor dose per field was 3600.

Infra L. Pubic — Identical with the above.

*May 1961.

diagnostic criterion since both malignant and benign lesions can be transilluminated. This is one area where an error of commission affords less grief than to err in opening into one of the more common benign or inflammatory lesions. The generally accepted treatment includes high ligation of the spermatic cord and total extirpation of scrotal contents on the affected side.

Radiation, some assert, has afforded an occasional cure; but in the main, cure rates are not greatly increased over surgery alone.[8] Cell differentiation and the type factors follow the usual pattern of susceptibility to radiation therapy.

CONCLUSION

1. All masses of the scrotum are to be critically differentiated. Malignant changes in a previously described benign growth are to be suspected and biopsy with early removal advocated.

2. Primary neoplasm of extra-testicular tissues is no longer of only academic interest. They are more prevalent than previously supposed. Painless rapidly growing lesions in the scrotum should be biopsied early.

7. MacKenzie, D. W.: British Journal of Urology, 4:307 (1932).

8. Thorbjarnarson, B.: Archives of Surgery, 82:55 (April 1961).

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Employability of Cancer Victims

B. L. Vosburgh and H. M. Rozendaal, in the Nov. 1960 issue of *Occupational Medicine* (2:432) suggest that in appraising the employability of a cancer patient, the physician must know the survival and cure rates for the tumor in question. He also should review the patient's treatment with the attending physician, and consult the pathologist on histologic peculiarities, grading, radiosensitivity, and lymph node invasion.

When the prognosis is extremely favorable or ominous, the physician will have little difficulty determining employability. Skin cancers, for example, approach a 100% survival rate and should not disqualify a person from employment. The forecast is also favorable for bowel carcinoma manifested by polypoid adenoma. In contrast, patients with acute leukemias or carcinoma of the lung, stomach, or testis rarely are employable. Between the extremes, a large group deserve employment consideration, including [1] patients having malignant disease with a five-year survival rate of about 50% or higher, such as cancers of the oral cavity, thyroid gland, colon, breast, uterus and cervix, and, possibly, the prostate gland; and [2] patients having an inevitably fatal disease of varying life expectancy, such as chronic leukemia and Hodgkin's disease. With Hodgkin's disease, a supposition as to outcome can be based on [1] type of the disease, with a good chance of prolonged survival for paragranuloma, less hopeful for granuloma, and poor for sarcoma; and [2] stage of disease, with a much improved outlook when only one or a few lymph node groups are affected than when disease is extensive. Because of the unpredictable course of chronic leukemia and the doubtful influence of treatment, patients should not be considered for *new* employment, even though therapy returns some patients to apparent and hematologic health for several years.

Thyroid tumors, often developing slowly for twenty-five years, exemplify the difficulty of prognostication. Patients having papillary adenocarcinomas often live for years, even with lung metastasis. The outlook is encouraging with adenoma and blood vessel invasion. On the other hand, the five-year survival rate for patients with giant-cell or small-cell carcinoma is not more than 20%.

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Neurosis, Conditioning and the Rule of Impression Priority*

In this simple and common-sense approach, Dr. Laughlin seeks to show how neurotic patterns are echoes of earlier life experiences.

A neurosis is an emotional illness. Patients with neurosis (unlike many cases of psychosis) usually have no marked loss of contact with reality. Neuroses vary widely in severity. Some symptoms cause minimal interference with living; others can be disruptive. A neurosis is of psychogenic origin. It is a disturbance of emotional adaptation. Symptoms of a neurosis appear because of unresolved emotional conflicts.

The neuroses today include some ten or twelve major groups of reactions: (1) The conversion reactions, (2) Overconcern-with-health, or hypochondriasis, (3) Depressive reactions, (4) Anxiety reactions, (5) Fatigue reactions and neurasthenia, (6) Dissociative reactions, (7) Obsessive-compulsive reactions, (8) Phobic reactions, (9) Neuroses following trauma, (10) Soterial reactions† (converse of the phobias), and (11) Character neuroses.

Insights into Psychogenesis are Recent

Neurotic symptoms are widespread, if not universal. Our knowledge of neuroses has advanced a great deal in our understanding of the complex factors in the psychogenesis of neurotic manifestations. This advance has taken place within the last 75 years.

It may be hard to realize that as recently as the turn of this century Sigmund Freud still made a distinction between so-called "actual neuroses" and "other neuroses." In the former he included: neurasthenia, anxiety neurosis, and hypochondriasis because these, he thought, were due to physical exhaustion, irritation or external causes. The "other neuroses," he knew, had a psychogenic basis, which by then, was widely recognized and acknowledged.

Only a few years prior to this date (in the 1880's) Charcot firmly established the fact that symptoms of hysteria were of psycho-

*Read by invitation April 26, 1961, before the New Jersey District Branch of the American Psychiatric Association at the Annual Institute of the Veterans Administration Hospital, Lyons, New Jersey. This paper represents the Beling-Englander Memorial Lecture, an annual lectureship sponsored by the psychiatrists of New Jersey.

†You won't find this word in your medical lexicon, but if you have a king-sized unabridged general dictionary you will see *soterial* listed as a theologic term meaning "pertaining to salvation." Actually, the Greek word means "good health" or "preservation" or "security," the "salvation" concept being a theologic extension of meaning. In its psychiatric use, the word was suggested by Dr. Laughlin, himself in the 1955 edition of the *Psychiatric Glossary* published by the American Psychiatric Association in Washington, D. C. It was more fully defined the following year in Dr. Laughlin's text *The Neuroses in Clinical Practice* (Philadelphia 1956 Saunders) in these terms (page 198):

"For the kind of emotional reaction that is the reverse of the phobia, I should like to propose the name *soteria*. This word is carried over by direct transliteration into conventional English letter equivalents from the Greek word *soteria* which conveyed much of the meaning of security, health and protection often attached neurotically to the soterial object."

The word is so useful, that it is surprising that it has not worked its way deeper into the psychiatric lexicon. It does not appear in the 1957 edition of the American Psychiatric Association's *Glossary*, nor so far as we have been able to determine, is it found in the index of any current psychiatric text. Nevertheless, it is a handy term and there is no other single word that quite conveys the meaning. It should be used more.—*Editor*

genic origin. In a series of noteworthy experiments he showed groups of visitors at his clinic the production and dissolution of symptoms in subjects under hypnotic suggestion. These were identical with the symptoms of hysteria, then widely encountered in the clinical practice of medicine. This was a major milestone in the understanding of hysteria and of all related emotional symptoms. Many prior sceptics could then acknowledge that there might be something to psychogenesis; that symptoms could *originate* through emotional bases. Today we know this to be a basic truth.

MORE PSYCHOLOGIC RESEARCH DESIRABLE

THERE have been many contributors to our psychologic knowledge, and many contributions. Still, today, we may be more "organically oriented" than we might like to acknowledge. If one counts the articles in our professional psychiatric journals, those contributing to psychologic theory (or seeking to develop and expand existing insights) are far in the minority. It is more difficult to secure publication of a careful study of a mental mechanism, for example, than it is to find space for the report of the testing of a new drug. I suspect the former is also less likely to be read, is more subject to criticism, and is more likely to be considered "controversial."

Accordingly, I think it is in order to make a strong plea for more contributions to psychologic theory and to our seeking to unravel further the mysteries of the psychogenesis of emotional symptomatology. Let us also be more accepting, open minded, and more charitable in our reception of these contributions.

PAVLOV AND CONDITIONING

I WOULD like to recall briefly the work of the Russian psycho-physiologist, Ivan P. Pavlov, who lived from 1849 to 1936. He made many noteworthy contributions through animal experimentation. Pavlov observed the effects of repeated identical stimuli on laboratory animals and their responses to these stimuli. He found that an automatic response which was appropriate to a given stimulus could be secured in response to a new stimulus, through a process which he called "conditioning."

In one of his most frequently cited experiments, a dog was offered food and at the same time a bell was rung. After many repetitions, the sound of the bell came to be associated by the dog with the offering of food. Following sufficient repetition, Pavlov learned that the ringing of the bell alone would elicit the same salivary and gastric preparation for the reception of food as had the food alone. The salivary and gastric response had thus become *conditioned* to a new stimulus. The two stimuli (food and bell) had become associated. Either one would automatically elicit physiologic responses.

Concepts of the conditioned response and of conditioning are important in the behavioral sciences. It is not possible to carry over simply or directly all the underlying principles from this kind of animal experimentation into the far more complex studies of emotional reactions and the behavior patterns of human endeavor. Many applications, however, have been attempted. As one consequence, the concept of "conditioning" has secured a firm place in our scientific vocabulary.

Certain scientists have tried to carry over applications of the conditioned response directly into human experimentation. As I have reported elsewhere,[1] the successful instances of "brain washing," prisoner processing, or human conditioning (as this perverse science has been variously labeled) bear macabre witness to the effectiveness of their efforts.

THE RULE OF IMPRESSION PRIORITY

AS WE work out, test, and apply psychologic theory and as we seek to develop it further, we find that the complexities and subtleties of human emotional responses re-

1. Laughlin, Henry P.: "The Neuroses in Clinical Practice." Philadelphia 1956, Saunders. Additional references will be found *passim* in that volume.

quire us to seek continued modifications and refinements. As one aid in this area, I have come to accord increasing respect to a basic psychologic premise which I have earlier named *The Rule of Impression Priority*. This "rule" is based on the thesis that first impressions ordinarily tend to take an emotional priority. The earlier impression will have more significance and carry more weight than a subsequent one of equal strength. Accordingly, the impressions gained on a first visit, an initial meeting, the original experience in a new sport or activity, the first day at a new school, and the initial contact with an employee or employer, all have special significance.

Subsequent events, attitudes and history can be profoundly influenced by what happens and by one's emotional reaction subsequent to a first experience. The first impression has a kind of emotional priority. Other things being equal, earlier impressions are more significant and carry more weight than do subsequent ones. The Rule of Impression Priority is an important one in human psychology. The study of many phenomena in emotions and behavior will demonstrate its influence.

THE NEW PATIENT

THE concept of emotional priority has an important application in the situation of meeting a new patient. The initial interview is likely to be of far greater import than say the twelfth, or the twenty-third. In fact, if it doesn't go well, there may be no twenty-third, or twelfth, or perhaps not even a second session!

It is of major importance therefore that one's first contact with a new patient get off "on the right foot." This is crucial for the patient. It is of great importance for the therapy, and for the therapist. One wants the patient, for example, to gain some idea of what to expect in subsequent visits. One also needs to avoid his securing unreal expectations. He needs to learn early in the relationship what is to be expected as to his part in the therapy, his contributions, and the receptivity of the psychiatrist. It is better also to get settled fairly early such matters as those of fees, payment, frequency and usual length of sessions, absences, and other practical matters.

The importance for the relationship and the therapy of the initial impressions can hardly be overstressed. The Rule of Impression Priority begins to operate from the first telephone call to the physician at his office, and from the first personal contact of the new patient. More of our so-called therapeutic failures date from initial contacts with patients than we wish to recognize. An unsatisfactory first contact can add up to a therapeutic failure even though it also becomes an *only* contact.

In psychotherapy as in the initial phases of other important relationships, other factors help give them added relative weight. It is far harder to "unlearn" an emotional attitude and replace it with a new one than to begin with the preferable one in the first place. It is easier to start with good habits and favorable attitudes than to alter bad habits or antagonistic attitudes once established.

INITIAL IMPRESSIONS COLOR SUBSEQUENT ATTITUDES

INITIAL impressions can influence subsequent behavior in automatic or semi-automatic fashion. Patterns of reaction can, in a sense, be learned, *i.e.* influenced by early experience. This is easier to illustrate with initial impressions which are of the painful variety.

A young woman had a frightening accident the first time she drove a car. While other factors influenced this situation, this painful initial experience played a major role in her reactions to driving. Driving became an unpleasant duty or necessity and continued so for many subsequent years.

A 36-year old woman has refused to ride in a plane following the ending of her initial flight nine years ago in a forced landing in which her plane wound up in shallow water off the end of a runway. In another instance, a young man in a "horsy" family would become nervous and apprehensive every time that someone suggested riding; his initial experience having ended disastrously when he was a small boy.

A 40-year old patient was talking about his activities and interest in various sports recently: "Baseball—I never did too well in that. I got

smacked in the side of the head by a ball when I was 9 and that really dimmed my ardor for playing ball. That was all that was needed to discourage a boy who was already only half-way encouraged to start with. As a result, I never liked it too much or played very well."

The early accident had influenced this man's subsequent attitude, in line with its prior position experientially. One might wonder, of course, if it would have had the same influence without the impact of its prior position. This patient thought not, citing other injuries and mishaps of equal moment suffered in connection with other sports, especially in ice skating and ice hockey, for example, in which he was interested and proficient.

THE PRINCIPLES OF IMPRESSION PRIORITY MAY BE DELIBERATELY EMPLOYED

At times the priority of first impressions is used purposely to achieve some desired result. A colleague finding his young teen-age son with a forbidden cigarette encouraged him to smoke an entire cigar! This was several years ago. The son has not smoked since. I have also known of instances in which this kind of approach was used by parents to establish desired attitudes toward alcohol, and toward sexual activity.

One day I observed an unmanageable horse brush his rider off against thickets and trees. The horseman angrily led his mount back to the scene and struck him repeatedly, after which the horse could not even be induced to return to the scene of the beating.

LEARNED RESPONSES CAN BECOME AUTOMATIC

I mentioned that patterns of reaction can be, in effect, learned and there are many instances of this. Many approach or are actually automatic. Recall the common tendency to push down on the floorboard when one is a passenger in a car and wants to see the brakes applied. Such a response does not occur in children. It appears only after one learns to drive or at least thinks in these terms.

This type of response is hardly handicapping or self-defeating and therefore is not considered as a neurotic manifestation. Let us progress a bit further to a learned and adopted type of response that can be all of these. This brings us to the matter of patterns of reaction in behavior and attitudes.

COMPULSIVE OVEREATING

Several years ago I was working with a young lady who suffered from a number of problems, one of which was the very tough one of compulsive overeating and obesity. This was a seemingly intractable pattern. It became gradually possible to link it to eating as a source of comfort and security.

Compulsively she would turn to food, particularly cookies, sweets and ice cream when disappointed, hurt, or anxious. For her these items and their ingestion were an important *soteria;* the soteria being the converse of the phobia.

A SOTERIAL REACTION

In the phobic reaction the object of phobia is a neurotic source of fear, dread and danger. In the soteric reaction,† the soterial object is a neurotic source of solace, comfort, and security. In the cartoon "Peanuts," Linus' blanket is his soteria, as similar objects are to many small children. For an adult, soterial objects include amulets, good luck charms, a religious object or some type of medicine. A patient may feel "safe" or comfortable if some smelling salts or tranquilizers are readily available. These may be seldom or never used, but take them away and the patient will be tense or anxious—will feel unsafe. A soteria counters fear and anxiety.

Patients seldom complain to us about their soterial objects, so there is less incentive to study and to understand them. Who seeks to resolve and perhaps have to surrender a source of comfort, solace, or security? It is of no help that this kind of reaction can operate

unwittingly, or partly so; in fact, this relative non-awareness can be a further hindrance to study and understanding since the reaction thereby becomes so much less accessible. Like other neurotic reactions, the soterial reaction thus becomes so much less possible to cope with from a therapeutic standpoint.

AN EARLIER PATTERN IS RECALLED

ONE day in her tenth month of intensive therapy, in a burst of recall, my young obese patient related seemingly forgotten events from her second to fourth years (of age). Her elderly nurse had learned an easy way to pacify the child through candy and other sweets. Let the child fret a bit and the nurse, taking the course of least resistance, would pop something sweet into her mouth.

The child never had much chance to learn other or more effective and healthy ways of handling her hurts, disappointments, and frustrations. As she recounted repeated instances of this kind of sequence, she quickly recognized its fundamental indication in her current problems. With racking and bitter sobs she very correctly assessed how cruel and heartless this way of managing her had been. The pattern thus induced had become an integral part of her emotional adaptation. Operating automatically through the years she had been helpless in its grasp.

This insight constituted a major breakthrough in the work of therapy. It illustrates for us the important priority of the early influences. It also provides an example of the conditioning effect of the early induced sequence of reaction upon later patterns of response.

VARIATION IN SLEEP REQUIREMENTS

MANY emotional areas illustrate the relative importance of early impressions, the "rule of impression priority," and the conditioning effects upon subsequent attitudes and patterns of reaction. More recent ideas about sleep would suggest less need for emphasis upon an arbitrary number of hours spent each night sleeping. This seems more a matter of individual adjustment, emotional reactions and (perhaps less surprising at this moment of writing) of the person's attitudes and beliefs about sleep.

Thus, what one has heard in early years about sleep and his relative need for sleep, from parents, health authorities and other significant adults may influence his attitudes about sleep in later life. The subjective need for sleep can be variable. This can play an important role in the relative need for sleep. Indeed this may be more important than many physical and more objective factors. Thus, one's need for sleep may tend to become in actuality what one has emotionally come to feel it ought to be.

PREJUDICES, SCHOOL AND LEARNING

PREJUDICES about races, groups, and religions often develop as a kind of emotional contagion from prejudicial ideas and attitudes to which one may be early exposed. These constitute negative "first impressions," in the absence of preceding positive ones. Similarly, attitudes toward school, toward interest in a given subject, or indeed toward all learning, may be colored and influenced by what happens in an early class or in the relationships with a particular teacher.

THE HOMOSEXUAL SEDUCTION

WHY is the homosexually oriented individual so censured when he approaches the child or adolescent? Even those persons not otherwise critical of homosexual activity are likely to oppose this kind of outlet. The added danger here is in line with our thesis so far.

Here also the initial impressions of sex and sexual activity with another person can have a considerable priority in influencing subsequent desires, interests and patterns of sexual behavior. Early homosexual experiences can, in many instances, influence the subsequent

sexual orientation of the child toward the homosexual.

IMPRESSION PRIORITY AND THE FIRST SEXUAL EXPERIENCE

THE first sexual experience often establishes an important precedent in line with our brief about the importance of the "rule of impression priority." One may thus set the stage, so to speak. An adolescent seduction is usually more meaningful, can be more traumatic or influential, and can help establish subsequent attitudes and acts toward and about sex. Many times in evaluating the emotional adjustment of an individual, one learns of the first sexual experience of the patient and the importance this has had in his subsequent sexual adjustment and in his sought-after patterns of sexual activity.

COMPLEX AREAS

EMOTIONAL matters are complex. When we undertake their elucidation there is danger of over-simplification. This I wish to avoid. While we dissect for the purposes of this essay certain bits and pieces of psychologic reaction, and some principles which govern them in part, let us keep in mind always that we are dealing with the most complex aspects of the human being. The kind of simplification here illustrated is within the purpose of dissecting and tracing one particular thread. Psychogenesis has countless threads. While our present one is interesting and of some importance, we must bear in mind that it is only one of many.

PATIENTS SEEK PHYSICAL, NOT EMOTIONAL EXPLANATIONS

ONE way of reminding ourselves of the complex nature of emotional conflict is to call to mind a rather uniform reaction of our patients. We have all had experience with patients who seek to attribute emotionally based symptoms to physical causes. A physical basis may be desperately sought or clung to in preference to an emotional or psychologic one. This is not uncommon.

In contrast, how often do we hear of a patient seeking to find an emotional basis for symptoms of a physical cause? This is *most* rare. Even the cancer patient does not seek for a psychogenic origin for his symptoms.

APPLICATIONS ARE PROGRESSIVELY COMPLEX

IN DEVELOPING my topic today I have followed a path of increasing complexity. From the conditioned response of Pavlov's dog we have progressed to the "rule of impression priority." Here we considered the interesting priority which is likely to be accorded first impressions and were able to expand our thesis further to observe the additional weight accorded early influences in people's lives, and still further as we note the relative importance of early patterns of reaction in inducing ones which are automatically operative in later life.

As we progress we note two things: (1) the applications of the "rule of impression priority" become increasingly involved and complex; and (2) we are also observing consequences which are less and less "normal" and are more and more in the realm of psychopathology.

ANTECEDENT PATTERNS AND NEUROSIS

WE ARE now ready to consider application of our ideas in areas of more specific neurotic symptomatology. These are legion and I shall content myself with two examples and leave it to you to observe the many possible and interesting additional applications to be encountered in your work with your patients.

RECAPITULATION OF EARLIER EXPERIENCE

THE following instance illustrates how earlier attitudes and relationships can unwittingly call

forth analogous emotional responses, when elements of a later situation appear similar to the individual concerned. The later response occurs automatically. Its basis is "unknown" to the person concerned without special study. He is accordingly at a loss to explain the presence or the strength of his reaction.

Two years ago a married woman entered therapy complaining among other things of irritability with her child Eddie. She described herself as "too angry," and said that her anger was out of keeping with what he might do. She feared that she might injure him. She noted frightening and inexplicable urges to strike him or to attack him.

Gradually we learned that as a girl she had been responsible in large measure and for a long time for the supervision and care of her younger brother, Bob. She had been the eldest child and from the age of eleven, she was required to become practically the mother for Bob, who was eight years younger. This was indeed a burdensome, demanding, and unwelcome responsibility, really far too onerous for her years, resources, and experience. At times she would become uncontrollably angry with him. She eventually recounted how she had knocked him down stairs one time, and on another occasion struck him so hard that his nose bled. She was terrified both times. As she recounted these instances and her emotional turmoil about them amid tears, with a significant slip of the tongue she called Bob, Eddie.

She had never before been able to admit to herself her resentment of either Bob or Eddie. Repression of these emotions had seemed vital to their control. Whenever "derepression" and loss of control had threatened, she had sought help. Conscious recognition and study during therapy led to acceptance, resolution of conflicts, and more control, rather than the feared reverse.

It became clear that the earlier relationship had set the stage for the later one. It had had a considerable influence in rendering the patient more vulnerable to a situation which she unwittingly experienced and reacted to as similar, and (in essence) a recapitulation. She was correct when she described her anger with Eddie as "undue" insofar as the external circumstances appeared. The earlier pattern of response exercised priority. Similar patterns of response were automatically evoked when the relationship with her son unconsciously recapitulated the conflicts and tensions surrounding the earlier one with her younger brother.

REPETITIVE PATTERN OF INTERACTION

Our final instance illustrates the persistence through adulthood of patterns of reaction originally adopted in childhood when found to be effective. Patterns of reaction in relationships tend to become, in essence, habits. They are likely to operate without either party being clearly aware of the interaction, its subtleties or its repetitive nature. Here again the first instance takes a prior position and when successful is far more likely to be adopted and used subsequently.

Betty, the mother of several children, living in a distant city, secured a promise of financial underwriting from her parents to install an additional second floor bathroom. This was to cost an estimated $1500. In the midst of this work, some alterations to the bedroom seemed desirable. One thing led to another, and before everything was finished the kitchen was also revamped, the living room expanded, *two* new bathrooms were installed! All of this came to a total bill of over $15,000!

Betty had not consulted her parents in the course of all this. Now she tearfully confronted them with the staggering bill. Overwhelmed, they finally agreed to contribute one-third of the total.

Betty's older brother, Tom, disgusted with what he viewed as his parents' coddling and unequal treatment of his sister, predicted that they would wind up assuming the entire cost. They did. There was ample basis for his prediction.

In high school she had wanted a new dress

and talked her father into granting permission. She came home with a hat, shoes, pocketbook and accessories, in addition to the dress, which totaled several times the original expenditure agreed upon! Father's objections were met with sweet talk and "Oh, I just had to, Dad. It was such a good buy!" and an appealing . . . "Look, I'll model them for you," mixed with tearful pleas for his understanding, approval and help. It was a successful performance.

There were many similar instances in which "poor" Betty went beyond her authority in getting what she desired and she was subsequently able to wheedle its being condoned in one form or another. An early pattern became established through its success and had persisted into adulthood.

At first glance this pattern might seem far removed from our concepts of conditioning and the "rule of impression priority." It is of an increasing order of complexity to be sure, and indeed other instances are often far more so. However, consideration of this and many other examples will allow their use in the service of further elucidation and understanding of the many applications of the "rule of impression priority" in psychodynamics.

How does this pattern fit in with certain of our criteria for neurotic symptoms? How is such a pattern handicapping to Betty? In view of its successful operation over many years, what is the self defeat?

True, she has gained certain material things. However, has this pattern contributed to her self-sufficiency, her self-reliance, her independence, or to her maturity? It has not. Instead it has interfered with, prevented, or at least retarded the attainment of such emotional goals. Further, who fills such a position when her father can no longer do so? Others are not likely to be so accepting, cooperative, or charitable now, or in the future. In lesser matters a friend would be likely to resent any such presumption, even far less striking, along similar lines. Accordingly, there is clear handicap and self-defeat in the patterns which can rightly be considered neurotic. Thus, the neurotic pattern secures external secondary gain; but in accord with all neurotic symptoms and patterns, the net result from an objective viewpoint is a loss.

6800 Hillcrest Place

Diabetes Films Available

Moving picture films on diabetes suitable for both professional and lay audiences are available through the New Jersey State Health Department.

One film, "Diabetics Unknown," is a production of the Public Affairs Committee and is suitable for lay audiences. A 16-millimeter black and white film, it runs for 30 minutes. A pamphlet published by the Public Affairs Committee, also entitled "Diabetics Unknown," is available for use in connection with the film. Copies of this pamphlet and film may be secured from the Diabetes Control Program, New Jersey State Department of Health, Trenton 25, New Jersey.

For professional audiences, the Department suggests "Long Range Control of Diabetes." This 16-millimeter film is in sound and color and runs for 45 minutes. It is appropriate for practicing physicians, residents, interns, medical students, nurses, dietitians, public health workers, dentists, podiatrists, and medical social workers. It is not suitable for untrained, lay audiences or diabetic patients. You may borrow this film by writing to Administrative Services, New Jersey State Department of Health, Trenton 25, New Jersey.

"Diabetes and Its Long Range Control" was made for the New Jersey State Department of Health by the Medical Film Guild. Funds for the film were provided by the Department and the United States Public Health Service. In this film Dr. Charles H. Best, of Toronto, discusses diagnostic and treatment problems. Dr. Hugh L. C. Wilkerson, former Chief of the Diabetes Field Research and Training Unit, United States Public Health Service, illustrates case-finding technics.

Burton M. Cohen, M.D.

Elizabeth

Recent Advances in Chronic Pulmonary Emphysema*

Mechanical aids to respiration are arousing unusual interest these days, and Dr. Cohen's compact monograph will be helpful to those seeking to develop departments of Inhalation Therapy.

"Bodies of men and animals generally are nourished by three kinds of nourishment and the names thereof are solid food, drink and wind. Wind in the body is called breath, outside it is called air. It is the most powerful of all, and in all, and it is worthwhile examining its power... A man can be deprived of food or drink for two or three days and live, but if the wind passages of the body be cut off, he will die in the brief part of a day, showing that greatest need of the body is air."

—*Hippocrates*

The fundamental dependence of man upon the air he breathes has been appreciated since antiquity. The recent increased use of oxygen and therapeutic gases has been paralleled by the introduction of new means of administration, requiring appreciation of the physiologic bases of treatment. These devices attempt to correct oxygen deficiency, carbon dioxide overproduction or retention or combination of these defects. This presentation will highlight certain of the newer approaches to the physiologic therapy of chronic diffuse obstructive pulmonary emphysema.

Portable Oxygen Devices. Portable oxygen tanks of different sizes may be employed, usually with mask administration for the short-term treatment of the hypoxic patient. Barach [1] has introduced two new types of oxygen equipment well-suited for the ambulatory patient. One is a two and three-quarter pound oxygen cylinder containing about 180 liters of oxygen under 1800 pounds pressure. The cylinder may be strapped over the neck or shoulder of the patient, so that it hangs at the side. The regulator is set at any desired flow-rate; a flow of 6 liters per minute permits a patient to walk for 30 minutes at a moderate rate without dyspnea; 4 liters per minute prevents breathlessness in most emphysematous patients, while 2 liters per minute flow rate alleviates resting dyspnea.

The second of these newer portable devices is the cigar-shaped "Oxy-hale"® which holds a 3-liter oxygen cylinder under 5,000 pounds pressure; 3, 5 and 8 cylinders can be manifolded into the basic apparatus to provide from 9 to 24 liters of pure oxygen. A *venturi,* or mixing device, and an adjustable sleeve attached to the cylinder casing permit the pure oxygen in the "micro-cylinder" to suck in 3 to 18 liters of air, providing a larger volume of oxygen-enriched atmosphere for emergency inhalation. The various sleeve settings permit adjustment of oxygen concentrations from the low percentages adequate for the emphysematous patient to the 90 per cent or more required by patients with coronary artery disease and/or congestive heart failure. The small size of the Oxy-hale® makes it ideal for the

*From the Thomas J. White Cardiopulmonary Institute, Pollak Hospital, and the Seton Hall College of Medicine, Jersey City. Dr. Cohen is Assistant Professor of Clinical Medicine, Seton Hall College of Medicine; and Associate Director, White Cardiopulmonary Institute.

patient to carry in pocket, purse or briefcase. Studies by Segal[8] with this apparatus indicate that one minute of therapy with 18 inhalations at a sleeve setting to provide 40 per cent oxygen is capable of raising arterial oxygen saturation from a control value of 57 per cent in a hypoxic patient to 93 per cent after one minute, with values remaining above pre-treatment levels at the end of five minutes following cessation of the therapy!

Intermittent Positive Pressure Breathing on Inspiration (IPPB/I): The intermittent application of positive pressure to the upper airway during the inspiratory phase of breathing has been the most popular of the mechanical devices which attempt to establish a pressure gradient between the mouth and the pleural space. In some places IPPB/I has assumed the character of an act of blind faith, almost approaching a revealed religion.

Treatment is carried out with a system connecting pressure-tight masks or mouthpieces worn by the patient with a flow or pressure-sensitive inspiratory demand valve which delivers compressed gases from storage cylinders or other external sources. The patient's own breathing pattern controls cycling of the valve; when the inspiratory pressure in the system reaches a pre-adjusted peak the valve trips and the flow of gas ceases. Expiration follows as a purely passive process produced by the elastic recoil of the lungs and chest cage. The next inspiration resumes the flow of gas through the valve, inaugurating another cycle.

Most IPPB/I machines incorporate flow principles which permit instantaneous flow-rates large enough to satisfy even the most breathless patient. These devices inflate the lungs to a greater degree than occurs with normal inspiration, enabling the patient to obtain a more adequate ventilation without increased breathing effort. Fluoroscopic examination commonly documents more efficient diaphragmatic excursions and improved pulmonary aeration, particularly at the lung bases. The bronchi widen and elongate during the inspiratory phase and bronchial resistance decreases. Improved bronchial drainage is attributed to the development of higher peak flow-rates during the expiratory side as compared with the inspiratory side of respiration in patients receiving IPPB/I. Segal[8] reports decreased maximum minute ventilation and vital capacity values in patients with bronchial asthma and pulmonary emphysema receiving IPPB/I alone. He also notes that this therapy, in concert with bronchodilator aerosols, produces significant improvement in these measurements. In normal subjects and patients with chronic broncho-pulmonary disorders the respiratory minute volume increases, usually as a result of better tidal volume. Intrapulmonary gas distribution is facilitated, the alveoli are ventilated more uniformly and the residual volume of air in the lung is reduced; a higher arterial oxygen saturation results. The temporary hyperventilation induced by IPPB/I washes out the increased arterial carbon dioxide present in many emphysematous patients, correcting respiratory acidosis and enabling the breathing center to regain its sensitivity to endogenous and exogenous carbon dioxide stimulation. IPPB/I therapy may be, therefore, considered a safer method of administering oxygen when respiratory acidosis is present, a situation in which the conventional methods, by reducing hypoxia alone, may depress respiration dangerously and allow carbon dioxide build-up.

Hemodynamic studies made during IPPB/I therapy confirm a fall in cardiac output associated with treatment. With a peak inspiratory setting of 20 centimeters of water these changes do not appear to be of sufficient magnitude to affect most patients adversely. Upon cessation of therapy the recovery of cardiac output is prompt and complete. Variations in right ventricular stroke volume are crucial in relation to these changes in cardiac output. When the circulating blood volume is normal, vascular tone adequate and reflex vasoconstriction possible, the peripheral pressure rises with the rise in pressure induced in the right auricle, capillary filtration is enhanced and water lost into the tissues. If sympathetic pathways are ineffective, or if maximal reflex vasoconstric-

tion has already taken place, the venous gradient may be abolished leading to a drop in venous return, cardiac output and arterial blood pressure in sequential fashion.

Excessive pressure differences during IPPB/I can produce overventilation with respiratory alkalosis and tetany. Overdistention of the lung may occur. A high pressure exerted for a short time may be safer than a lower system pressure applied over a longer period. Any increase in intra-thoracic pressure may be injurious to patients in shock, or in situations where the venous return is already hampered. If positive pressure is transmitted along the gastro-intestinal canal, the stomach and intestines distend, producing undesirable vagal reflexes, progressive difficulty in expanding the lungs and further interference with venous return. Some observers have reported progressive right heart failure with peripheral edema due to ill-advised IPPB/I management, but this has been most uncommon in my experience.[5]

Intermittent Positive Pressure Breathing on Inspiration is contra-indicated if there has been recent pulmonary bleeding, mediastinal emphysema or spontaneous pneumothorax and in the treatment of patients under circulatory stress. Congestive cardiac failure, without circulatory collapse, is, however, most responsive to IPPB/I application. Lastly, the concomitant administration of bronchodilator aerosols, particularly in children, may induce a high blood stream concentration of drug in rapid order, leading to undesirable pharmacologic effects upon an already-embarrassed circulation.

Favorable results with IPPB/I have been reported in bronchospastic states, chronic bronchitis, bronchiectasis, diffuse obstructive pulmonary emphysema, bronchial asthma, pneumoconioses, atelectasis, pulmonary fibrosis, pneumonia, pulmonary edema and in the prevention or relief of carbon dioxide retention with respiratory acidosis. It is of assistance in the expansion of the unexpanded lungs and correction of the partial atelectasis of newborns and in the treatment of anoxic infants in general. In childhood asthma, IPPB/I may halt the progress of the disease, often reversing so-called "chronic" changes due to edema, bronchospasm and emphysema. Combined with antimicrobial and mucolytic agents, this therapy offers effective treatment for infection and atelectasis, as well as prophylaxis against recurrence of these complications, in cystic fibrosis of the pancreas. Postoperatively, IPPB/I is helpful in preventing pulmonary complications, particularly atelectasis, which often follow the use of cough-suppressing analgesics, tight dressings and prolonged immobilization. Further indications arise in the management of depressed respiration due to alcohol, barbiturate or narcotic intoxication, and in other emergencies involving inadequate breathing such as may occur in poliomyelitis and other neurologic disease. In this last circumstance, there is no significant difference between assistance to respiration rendered by such positive pressure at the upper airway (mouth or tracheotomy stoma) and application of negative pressure around the body, save for the greater ease of patient care allowed by IPPB/I.

In this country, the most frequently employed devices are the Bennett, Dotco (formerly Halliburton), Emerson, M.S.A. and Monaghan therapy units. Prolonged experience with the newer Bird Mark VII apparatus indicates that this is a particularly satisfactory and sensitive IPPB/I unit for daily patient use. A variety of aerosols may be administered by various nebulizer attachments. Air, 100 per cent; oxygen, 40 per cent; oxygen-helium-oxygen mixtures may all be utilized; a wide variety of tank and wall models and compressor units are commercially available.

It is mandatory that treatment be given only by a trained therapist under a physician's specific prescription and supervision. Gaining the patient's confidence is paramount. Many individuals tend to overventilate initially, so that mild tetany may ensue. This can be prevented by instructing the patient to breathe deeply

and slowly, allowing sufficient time for complete exhalation. Positive pressure will then take over the individual work of inspiration and the valve will cycle with minimal effort. The valve should be set for low pressures during the first few treatment sessions, with progressive increases of setting until a range of 15 to 20 centimeters of water is attained. Pressures above 12 to 15 centimeters of water are not desirable in patients with heart disease or a history of antecedent spontaneous pneumothorax or mediastinal emphysema or when giant air cysts are present. Treatments are given for 15 to 20 minutes three or four times daily for two to three weeks or as long as continued improvement occurs. Adjunctive oral and parenteral medication and physical therapeutic measures should be employed in concert.

Exsufflation with Negative Pressure: Inability of patients to cough up mucous plugs or aspirated matter is a frequent source of disability in many situations in medical practice. An ineffective cough reflex results from the respiratory depression accompanying the use of sedative, narcotic and anesthetic drugs, in intoxications and coma of all causes. Impairment of the skeletal musculature of the chest and abdomen due to neurologic disease, neuromuscular pathology, rib-fractures, tight dressing and casts may lead to similar effects. In chronic and acute broncho-pulmonary diseases the natural mechanism for bronchial catharsis is impaired or fails, and an effective cough is not obtained. Extensive study by Barach and his associates[2] led to the introduction of mechanical measures promoting better drainage of the respiratory passages utilizing "EWNP" or "the more rapid blowing out of air from the lungs during the expiratory cycle."

THE EWNP device ("Cofflator," O.E.M. Company) consists of a high speed blower motor unit which introduces into the lungs via a patient mask or mouthpiece, a large volume of air. At the moment of peak inspiratory pressure, ranging from 20 to 40 millimeters of mercury, a valve is automatically switched to negative pressure, producing a sharp drop in pressure which sweeps secretions and foreign matter mouthward. The length of inspiration and expiration are set at 1.5 to 2.5 seconds. This rapid drop in pressure, from 40 millimeters (mercury) *above* atmosphere to 40 millimeters *below*, within 0.02 second's time, produces an expiratory flow-rate equal to, or surpassing that of natural, normal vigorous cough, effects that cannot generally be achieved following IPPB/I therapy.

The bronchi are markedly widened at the peak EWNP inspiratory pressures, enabling air to traverse points of mucous-plug obstruction and to penetrate deeply into the distal alveoli; this enhances the effect of the high expiratory flow-rate and moves secretions upward and out. Like IPPB/I the use of EWNP leads to greater diaphragmatic motion, better ventilation and drainage of the lungs, particularly of the lower lobes. The hyperventilation resulting leads to reduction in arterial carbon dioxide pressure and an increase in blood pH and arterial oxygen pressures in postoperative and emphysematous patients. Cardiovascular effects are those of positive-negative pressure devices in general, but the slight increase in venous pressure is below that seen with the use of tank respirators or IPPB/I machines. Minimal rises in blood pressure and heart rate are common; electrocardiographic effects are limited to axis shifts such as are observed normally during deep inspiration and expiration. Measurement of intra-gastric pressure, and thus, indirectly, of intra-abdominal pressure, showed that the mean peak pressures with EWNP did not exceed 40 millimeters (mercury) compared with 90 millimeters during a vigorous natural cough, data suggesting that the patient treated with EWNP may experience less strain on a recent abdominal operative incision than would occur with ineffective, unsupported normal cough.

Patient cooperation is necessary for maximum effectiveness of EWNP. The patient should be urged to relax during the inspiratory phase, permitting the air volumes delivered to enter the lungs passively. Expiration should also be passive, and the patient must

refrain from attempting to exhale or cough on his own during this phase of the cycle. The optimal use of EWNP follows the preliminary use of bronchodilator or mucolytic aerosols. Treatment is generally given several times daily, each application of the apparatus consisting of 5 or 6 series of 8 to 10 respiratory cycles.

In comatose patients relaxation of the cardiac sphincter of the stomach may occur, and a stomach tube should be inserted prior to EWNP to prevent gastric dilatation. In poliomyelitis patients treated in the tank respirator the foot of the respirator should be elevated to take advantage of the increased bronchial drainage of the head-down position. Suction must be at hand, so that exsufflated material caught in the upper respiratory passages may be aspirated. The tracheotomized patient is treated either by connecting the EWNP machine to a cuffed tube inserted through the tracheotomy, or the tracheotomy tube can be corked and the treatment applied at the mouth.

Physical Therapeutic and Adjunctive Aids: Alterations predominantly on the expiratory side characterize the physiologic disturbance present in pulmonary emphysema. Air-trapping, prolongation of exhalation time and increased muscular exertion and work of breathing all impose massive handicaps, to which a diminished and ineffective cough reflex is additive. Purposeless, uncoordinated and inefficient patterns of respiratory muscle performance are standard.

Miller [7] has emphasized the advisability of tailoring physical reconditioning to individual patient requirements, taking into consideration the particular disease, the physiologic alterations present and their emotional setting, the patient's ability to understand and respond to training and the existence of sufficient rapport among doctor, patient and therapist to assure success. Even the most enlightened subject is unable to comprehend or attempt the entire gamut of corrective procedures at once, and each measure must be introduced sequentially, allowing ample time for demonstration, practice and rest. Evacuation of sputum, using forced coughing, postural drainage and EWNP, should be carried out prior to each session; priming with bronchodilator aerosols, particularly in conjunction with IPPB/I is particularly valuable. Correction of the postural defect of the childhood and adolescent asthmatic is important, and group therapy may be useful in such situations. Preliminary instruction must be directed toward simple measures to encourage physical relaxation and stretch the musculature of the shoulder girdle and upper chest wall.

Barach [3] has stressed the benefits to be derived from the 15 to 30 degree head-down position in this curriculum. Comfortable pillows are placed beneath the head and additional padding used if skeletal deformity is present. Good positioning may be ascertained by fluoroscopic inspection of the excursions of the diaphragm, if one utilizes the tilting x-ray table for early treatment. Angle-iron boards, elevation of the foot end of the hospital bed, use of a hydraulic bed-lifter or the convenient "Head-down" chair and table suitable for home management all assist proper positioning. An 8 to 10 pound sandbag placed over the upper abdomen increases intra-abdominal pressure and aids in diaphragmatic elevation.

Pursed-lip breathing, consisting of a slow exhalation against constricted lips, is a mandatory portion of the program. This maneuver increases pressure within the airways during exhalation, lessening the tendency for early collapse of the bronchi and inducing better airflow through the smaller respiratory passages. Contraction of the abdominal and expiratory chest muscles against this increased pressure leads to elevation of the diaphragm, so that the lungs are emptied more completely. Barach [1] lands the ventilatory advantage of the 15-degree forward-flexed attitude of the thorax ("gorilla walk") for the emphysematous patient during sitting, standing or walking.

Diaphragmatic re-education is also assisted by the oscillating bed. The effects in the head-down phase of the bed's cycle duplicate those of the tilt-tables and chairs mentioned; the

foot-down phase exerts a pull on the diaphragm in the footward direction. A pneumatic vest may be fitted to the thorax or abdomen and synchronized with IPPB/I treatments so that rhythmic inflation of the vest occurs during exhalation; both inspiratory and expiratory sides of the respiratory cycle thus become patient-controlled.

Further support of ineffective diaphragmatic motion follows fitting of either a Camp No. 820 or Barach-Gordon Emphysema Belt. The latter consists of two spring-metal bands attached to a pad positioned below the umbilicus; the lower band is the stronger and is designed to increase intra-abdominal pressure. The mechanical energy stored during descent of the diaphragm aids the recoil of the lungs during exhalation. The Emphysema Belt must be worn from the time of arising until the hour of sleep; its use is aided by the forward tilted position of the thorax.

In well-chosen instances, therapeutic pneumoperitoneum has real value, improving diaphragmatic contour, position and motion. While the emphysema belt provides a similar type of support, it is effective only during the hours it is worn, whereas pneumoperitoneum exerts its effects throughout the entire 24 hours of the day. Patients with relaxed abdominal muscles may require both the belt and pneumoperitoneum. Pneumoperitoneum finds its chief use in patients who cannot be taught abdominal and diaphragmatic breathing control, patients with excessive obstruction by accumulated secretions and individuals with a poor cough reflex. Simultaneous determination of the venous pressure may be a guide to the expected results of therapy; either a drop or little change in venous pressure occurs in patients who later achieve excellent results, whereas a rise in venous pressure has commonly foretold a poor response.

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Arthritis and Therapeutic Nihilism

A study* was made of 303 arthritic patients treated with placebos. The number of patients benefited was the same as the number favorably influenced by the methods of therapy reported in other studies. For example, 53 per cent of all arthritic patients were significantly improved by oral placebo. Of the remaining patients, 57 per cent (27 per cent of the total) were relieved by injections of saline solution. Thus 80 per cent responded either to oral or parenteral placebo. Results were not significantly different with salicylates or cortisone therapy.

*Traut, E. F. and Passarelli, E. W.: 1959 Illinois Medical Journal, 115:181.

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Choanal Atresia*

Report of Five Cases and a Review of the Recent Literature

Choanal atresia may rapidly destroy life unless it is swiftly recognized. Treatment is simple. What is hard is to consider the possibility.

Bilateral choanal atresia is a rare complication of the newborn. Prompt recognition of this inborn defect is lifesaving. Early diagnosis and successful treatment of two such cases prompts this report. These histories and a review of the literature are presented to alert obstetricians and pediatricians to this condition. Two unilateral cases and a case of bilateral atresia with multiple congenital defects are added to make a total of five cases during a ten-year period in a 407-bed community hospital.

Embryologically, the obstruction is due to a persistence of the bucconasal and buccopharyngeal membranes and the intervening mesodermal elements. The partition between the nasal cavity and the posterior nasopharynx may be thick or thin, depending on the quantity of persisting mesoderm. It may be membranous or bony, or a combination of the two. The obstruction may be complete or partial. Approximately 300 cases have been reported in the literature. About 36 per cent of these[1] were bilateral.

The presenting symptoms and signs of bilateral choanal atresia are dramatic. The newborn infant is delivered and takes its initial gasp. Thereafter, it is noted that respirations are difficult with suprasternal and infrasternal retraction indicating a high respiratory tract obstruction. Cyanosis increases with the fruitless efforts at respiration. Thick, clear mucus is noted obstructing the nares. When this mucoid material is removed by suction, there is no improvement in the breathing efforts. It is at this point that an infant airway, inserted into the posterior pharynx, will improve respiratory movements. Further efforts to clear the nasal passage by insertion of a suction tube through the nares into the nasopharynx will establish the diagnosis of choanal atresia. The catheter will coil on itself and fail to pass into the posterior pharynx because of a posterior choanal obstruction.

It has been observed[1] that the newborn infant (and premature infant particularly) breathes through the nose. This accounts for respiratory distress in choanal atresia. Mouth

*From the Hospital Center at Orange, Orange, N. J. This paper was read before the Orange Mountain Medical Society, April 21, 1961.

1. Roopenian, A. and Stemmer, A.: American Journal of Surgery, 96:892 (Dec.) 1958.

breathing is a habit acquired weeks or months later, during the crying experience. If the infant is "suctioned" and placed on his abdomen (allowing the tongue to fall forward) the condition may be temporarily relieved. However, when efforts are made to nurse, the infant is observed to experience cyanosis and respiratory distress.

MANY cases of asphyxia neonatorum are due to failure to recognize bilateral choanal atresia.[2] However, in premature infants, the condition may be unilateral, and, thus more difficult to recognize. With the prevalent custom of polyethylene tube alimentation through the nares, many a baby becomes cyanotic on passage of a tube through the nostril. It is at this point that the feeding tube should be passed through the opposite nostril to test its patency.

It is only because of an accurate appraisal of the presenting signs and symptoms of the dyspneic, cyanotic infant, and alertness to the possibility of bilateral choanal atresia, that the diagnosis may be made. The immediate treatment is to provide an adequate oropharyngeal airway by way of an infant anesthesia airway. Iodized oil† may be instilled into the posterior nares through the tube and the block demonstrated by roentgenogram. (Case 4)

Having established the diagnosis, subsequent treatment is to establish communication between the nares and the posterior pharynx. This is most simply accomplished by pushing a probe through the membranous partition and enlarging the opening from the anterior nares. If the partition is bony, the plate must be cautiously fractured, and then enlarged by rasps. The opening is maintained by the insertion of a No. 14 French catheter, or preferably by polyethylene tubes. These are less irritating to mucous membranes. These tubes are then sutured in place, or maintained by butterfly adhesive, as is done in nasal feeding. These airways must be kept free of secretion by suction and lavage. After four to seven days, these tubes are removed and the posterior choanal tissues are kept patent by anterior or retrograde bougie passage.

Periodic enlargement is required, as necessitated by the patency of the airway, for many months.

A word of caution about the use of the electric drill to pierce a bony partition. The danger is that the drilling may extend beyond the partition and penetrate the base of the skull with subsequent meningitis or hemorrhage.

When the true cause of the upper respiratory obstruction has not been diagnosed, tracheotomy has been done[1] as a lifesaving measure. This is unnecessary if the true nature of the pathology is realized, in fact, tracheotomy is contraindicated.

When one congenital anomaly occurs, there may be others. These should be sought for. Hanckel and Bates[3] reported such a case with accompanying polydactylism: Case 5. Dr. Lillien reports that the patient in Case 1 shows a gross malformation of the primary and secondary dentition of the child.

Whereas the transnasal surgical approach is satisfactory for the immediate treatment of bilateral choanal atresia, later definitive treatment, or for the treatment of late cases of unilateral choanal atresia[4] is indicated. Wilson[5] presents an excellent step-by-step transpalative repair for these conditions in later life. This treatise is recommended for the laryngologist who is called upon to repair these defects.

Three of our cases occurred in infants of Italian parents; one was of Jewish and one of Negro parents. This may be of no significance since our hospital is in an area in which live many Americans of Italian ancestry.

CASE ONE

Mother: para 0 Gray. 2. Boy was born at term after a five-hour labor. Pregnancy was uneventful. The mother had had an incomplete abortion at three months, one year previously. The baby weighed six pounds and showed marked respira-

†We used the Fougera brand, tradenamed Lipiodol®

2. McKibben, B.: *Laryngoscope*, 67:731 (August) 1957.

3. Hanckel, R. and Bates, G.: Southern Medical Journal, 50:1054 (August) 1957.

4. Poch-Vinals, R. and Calvo, R.: AMA Archives of Otolaryngology, 63:559 (June) 1956.

5. Wilson, C. P.: Journal of Laryngology and Otology, 71:816 (September) 1957.

tory distress with cyanosis at birth. The diagnosis of choanal atresia was made when a No. 8 French catheter could not be passed through either nostril. At the age of eight hours, a blunt probe and a small catheter were passed through the right nostril. The infant continued to have respiratory distress for 36 hours. On the fifth day, the catheter was removed. Breathing was satisfactory with intermittent suction.

On the eighth day, the cartilaginous obstruction in the left nostril was bitten away and a No. 14 French catheter inserted.

Thereafter, his condition improved remarkably. On the twelfth day the catheter was removed and the choanal openings were dilated daily for one week. At this point he was discharged. Periodic dilations were carried on for one year.

At the age of ten years, his breathing is normal. However, his dentition in the primary and secondary teeth is grossly abnormal.

CASE TWO

Baby girl: Mother para 1 Grav. 2. One brother born 13 months previously was normal. This baby was born after a two-hour uneventful labor with low forceps delivery under saddle block anesthesia. Birth weight five pounds ten ounces. At birth, the infant was resuscitated readily, but she developed persistent cyanosis with dyspnea. A large amount of clear mucus was noted at the nostril openings.

The infant was seen at three hours of age, with marked retraction of the suprasternal and infrasternal spaces, indicating a high respiratory tract obstruction. An infant airway was passed with slight relief. However, she was so dyspneic and hypertonic that it was difficult to evaluate the degree of relief afforded. A rubber No. 8 French catheter failed to pass through either nostril. The baby was then laryngoscoped to rule out laryngeal obstruction.

At five hours, without anesthesia, a sharp, awl-like instrument was passed back along the floor of the left nostril and encountered a cartilaginous obstruction just before the end of the hard palate. It was possible to go through the obstruction with the awl and then the opening was enlarged with a rasp and biting forceps until the opening was sufficient to accommodate a No. 14 French catheter. The same procedure was carried out in the right nostril. Both catheters were left in position and fastened at the front of the nose.

The infant had a stormy postoperative course, but when the tubes were maintained free of mucus, she did well. The tubes were removed on the fifth day. Suction was used as needed to maintain a free airway. Daily thereafter, the posterior nares were dilated with a catheter. She was discharged on the 18th day.

She has been dilated at weekly intervals for two months and then at monthly intervals. At 16 months she is a normal infant.

CASE THREE

A baby girl was delivered by cesarean section because of a previous section for pelvic disproportion. This was the second pregnancy. Birth weight was six pounds, thirteen ounces. The baby appeared to breathe well and no note of difficulty was made until she was seen by the pediatrician at 24 hours. He noted, "baby breathes as though there is considerable nasal obstruction. Holding mouth tightly closed, baby can breathe with effort. No. 8 catheter passed through nostrils to length of 3½ centimeters on each side—then apparent obstruction."

Consultation by Dr. W. Campbell: "I can pass a stiff director through left nostril into nasopharynx. No. 8 French catheter cannot pass through right nostril because of an obstruction two-thirds way back."

Three days later, under general anesthesia, a soft tissue obliteration of the right nares was found. It was not bone or cartilage. The obstruction was incised and dilated and a No. 12 French catheter was inserted in the nostril to prevent closure. A catheter could be passed freely through the left nostril.

Suction was used to clear the catheter but despite this the baby had severe cyanotic spells for the next 12 hours. This was relieved by moist air and suction. Thereafter, she improved and the catheter was removed on the fourth day postoperative and further dilatation was not necessary.

CASE FOUR

A six-week old female infant was admitted because of a cyanotic spell after vomiting. She had had a full term normal delivery but the mother noted that the baby had a lot of mucus from birth and had trouble feeding. At one week the attending pediatrician saw her for the first time and was struck by the profuse amount of nasal mucus. Erythromycin and saline nose drops were given. Examination at the hospital was negative except for substernal retraction and crusted edematous nostrils.

A soft rubber catheter was passed on the right, but could not be passed through the left nostril. Three days later, iodized oil* was introduced into the left naris and showed obstruction. A probe could be passed indicating a membranous obstruction on the left side. Nose culture showed hemolytic staphylococcus Aureus. No therapy was carried out at this time. At a later date, a membranous obstruction was pierced and dilated.

CASE FIVE

Mother para 2 Grav. 4. This was the first of heterozygous twins delivered by vertex presentation. The baby was born one month prematurely, weighing five pounds three ounces. He breathed

spontaneously but developed gasping respirations with cyanosis. His condition deteriorated steadily and he died 48 hours after birth.

Autopsy showed multiple congenital anomalies, including bilateral choanal atresia, rudimentary external ears, micrognathia and interatrial septal defect of the heart.

SUMMARY

THREE cases of bilateral choanal atresia and two cases of unilateral atresia are presented. Signs of high respiratory tract obstruction should draw attention to the possibility of choanal obstruction. Failure of a nasal catheter to pass into the posterior pharynx is diagnostic. Immediate perforation of the obstruction is curative, and lifesaving.

Grateful acknowledgment is made of the courtesy of John R. Gilmour, M.D., Bernard B. Lilien, M.D., Louis V. Belott, M.D., William B. Nevius, M.D. and Leon I. Small, M.D., in permitting the use of their cases.

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The Sale of Samples

The following is abstracted from the July 7, 1961 issue of *Medical World News*:

The Food and Drug Administration is launching a nation-wide crackdown on sale of drug samples which have been given to physicians and detail men. It charges that the practice violates both Federal law and "sound professional ethics."

FDA Commissioner George P. Larrick took the action after spot checks showed that some repackaging firms are doing a brisk business in buying up "hundreds of thousands" of free samples from doctors—or detail men—and then marketing them.

AMA officials say that relatively few doctors are involved. The drug industry is also launching a survey.

Records of one repacking company showed that a Brooklyn physician pocketed $10,000 a year from the sale of samples. A large drug repacker in Shiller Park, Ill., from whom more than $50,000 worth of samples were seized by FDA, got drugs from doctors solicited regularly by mail.

"Dear Doctor," his letters read, "Don't throw away your surplus drugs or samples. I will buy them from you. I pay a fair, honest price."

Another repacker considered it more effective to offer office supplies in return for samples, and he sought to assure doctors that doing business with him was proper.

After some high-level prodding, Commissioner Larrick launched a spot-check in the New York—New Jersey area to see if a nation-wide investigation seemed warranted. He quickly concluded that the business of selling samples is a "mushrooming abuse." The preliminary inquiry led to seizure proceedings against two New Jersey firms.

In the case of the New Jersey firms, the Government said that repacked articles included *Diuril* and *Hydrodiuril, Chloromycetin, Aureomycin, Terramycin, Equanil, Placidyl, Premarin and Thorazine*. It also alleged that the repackaged drugs were not labeled according to law.

Shiller Park inspectors found bottles containing the potent anti-depressant *Tofranil* labeled as *Donnazyme*, a drug for gastrointestinal conditions, or as "*Albee* with Vitamin C," a vitamin.

The nation-wide investigation being launched by the FDA has the strong backing of Health Secretary Abraham A. Ribicoff, and will be pushed in all sections of the country. It is expected that the Internal Revenue Service will take a look at tax records of doctors involved.

Trustees Meeting: June 18, 1961

Among the activities at the June 18 session of the Board of Trustees were the items below listed:

MEDICO-LEGAL MATTERS

The annual report of the Board had included the following:

> "It is the sentiment of the Board of Trustees that from a public relations standpoint, if this latest proposal fails, the courts—and the public of New Jersey, if need be—should be informed that through the consistent efforts of The Medical Society of New Jersey the medical profession has tried to do something constructive to improve the present situations in these areas of court concerns."

This suggestion was approved by the House of Delegates at its May 1961 meeting.

Action: The Board voted to send this information to the Administrative Director of the Courts of New Jersey.

There was discussion of the order of the Court requiring our Middlesex County Medical Society to accept as a member a graduate of an osteopathic school.

Action: Laid on the table pending developments with respect to relation to osteopaths which are expected to take place at the AMA annual meeting.

There was discussion of medical testimony in drunken driving cases. Considered were letters from nine safety committees of the N. J. Safety Council. These concerned the testimony of physicians in cases where persons are charged with driving under the influence of intoxicating liquor. They requested that the Medical Society, cooperating with the Attorney General, develop pertinent information on the problem of drunken driving and the reliability of chemical tests, together with court decisions which affect the testimony of physicians in these cases; and that this data be forwarded to all physicians in New Jersey. It was also suggested that physicians should be acquainted with the provisions of the law which formulate the various degrees of intoxication.

Action: Referred to our Special Committee on Traffic Safety for report back in the fall. Legal Counsel is asked to participate in this study.

PROPOSED MENTAL HEALTH CODE

The Board received, as an item of information the President's report that he had notified the State Commission on Mental Health that at the present time, in connection with A-647, 648 and 649, The Medical Society of New Jersey grants approval in principle and that more specific positions will be developed after due study and consideration.

PR COUNSEL FOR MEDICAL-SURGICAL PLAN

The Board was reminded of its House-approved recommendation with respect to the appointment of a public relations officer for Medical-Surgical Plan. The position was:

> "That the Board record its approval of this arrangement as potentially adequate but that it reserve the right, after a proper interval, to review the entire operation and at that time to make such further recommendations as it deems desirable.
>
> "That the Board be memorialized to reconsider this particular problem annually at the time that the nominations for the Plan Board of Trustees are considered, and at the expiration of the 'proper interval' proceed to weigh the adequacy of this new arrangement."

Action: The secretary is instructed to include this item on the agenda of the appropriate Board meeting each year.

MAJOR MEDICAL INSURANCE

The Board has been asked "to investigate and consider negotiations with private carriers

to furnish major medical insurance and similar services."

Action: Referred to Committee on Medical Defense and Insurance.

OTHER REFERRALS FROM HOUSE OF DELEGATES

Eye Care on Funded Basis: Proposed pilot plan was disapproved by the House and the unions will be so notified if inquiries are received.

Joint Rider: To be submitted to the component societies. It is noted that paragraph 3 of Resolution 12, adopted by the House reads: "That this Society express its continued opposition to all efforts by third parties, be they hospitals, insurance companies, or any others, to enter into the practice of medicine under any guise whatsoever."

Resolution No. 15—Medical Corporations or Associations: The House has approved the following: "Resolved that the Retirement Commmittee of The Medical Society of New Jersey be continued in office and investigate the possibility of obtaining the revision of the appropriate laws of the State of New Jersey permitting the formation of medical corporations or associations."

Action: Referred to the Special Committee on Retirement Plan for Physicians for study and/or recommendation and report.

REPORTS FROM OR FOR AMA DELEGATES

Resolution No. 2—AMA Dues Increase: This was supported by our New Jersey delegates and approved by the House.

Nebraska resolution filed as part of the annual report of the Board of Trustees, without prejudice, for the information of the House of Delegates—to review the AMA dues increase.

Resolution No. 4—Future Physicians Clubs: Adopted by the AMA was the resolution submitted by New Jersey Delegation:

"Resolved, that the American Medical Association recommend that all county medical societies assume active leadership in this field by organizing local Future Physicians Clubs for the purpose of recruiting talented and dedicated students for careers in medicine."

Resolution No. 8—Influenza Immunization Campaign: Approved was the following resolution sent to AMA by New Jersey Delegation:

"Resolved, that The Medical Society of New Jersey urges the American Medical Association to evaluate and give leadership to an anti-influenza campaign, similar to that given in the campaign against poliomyelitis."

Resolution No. 14—Relation of Medicine to Optometry: Adopted was the Tennessee resolution calling on the AMA House of Delegates to establish a Commission on the Relation of Medicine to Optometry, to conduct a broad study of the problems involved and explore all possible and desirable solutions.

Resolution No. 16—Assistant Secretary of Defense (Health and Medical): Adopted was a resolution to AMA by New Jersey Delegation: "Resolved, that the House of Delegates of the American Medical Association urge the re-establishment of the position of Assistant Secretary of Defense (Health and Medical); and be it further Resolved, that this resolution as adopted by the House of Delegates of the American Medical Association be forwarded to the President of the United States and the Secretary of Defense."

Resolution No. 18—Social Security for Physicians: The following was adopted as a resolution to AMA by New Jersey Delegation:

"That The Medical Society of New Jersey recommends to the House of Delegates of the American Medical Association that it approve compulsory inclusion of physicians under social security and support national legislation to achieve that end."

(New Jersey AMA Delegates were mandated to support this resolution or any other favoring the inclusion of physicians under the social security program).

ALLIED HEALTH SERVICES IN HOSPITALS

Received from the American Academy of Orthopaedic Surgeons, the resolution was approved and referred to the AMA Delegates.

KERR-MILLS LAW

Received from the Medical Associations of Alabama and Washington, in support of the Kerr-Mills legislation, the resolutions were approved and referred to the AMA Delegates.

FREE CHOICE OF PHYSICIANS

Upon motion by Dr. Allman—seconded by Dr. Greifinger, and carried—this resolution from the New Mexico Medical Society was referred to the AMA Delegates without instruction.

RESOLUTION CONCERNING ROTATING INTERNSHIPS

Upon motion by Dr. Ware—seconded by Dr. Allman, and carried—this resolution from the Ohio State Medical Association, was without instruction, forwarded to our AMA delegates.

INDUSTRIAL SAFETY LAWS

The chairman of the Special Committee on Industrial Health, Dr. Delma W. Caldwell, was appointed as the Society's official representative to the Governor's Conference on Industrial Safety Laws. The conference was held in Trenton on May 23, 1961.

In his report, Dr. Caldwell pointed out that, in January 1961, Governor Meyner established an Advisory Committee on the Health and Safety of Workers, which consists of ten or twelve individuals representing insurance companies, industrial hygiene groups, various labor units, the N. J. Manufacturers Association, and the New Jersey State Safety Council. There was no representative from medicine. One of the purposes of the conference was that it "may serve as a forum for the presentation of various points of view to guide the Governor's Committee in its study of the State's safety laws and possible proposal of new legislation in the field." It was the suggestion of the Governor's Advisory Committee that it be replaced by a smaller industrial safety rule-making board of five persons representing labor, employers, and the public at-large. This rule-making board would make the regulations for industrial safety with application through the various Executive and Judiciary branches of the State government. Dr. Caldwell urged that the State Society become an active participant in such matters of industrial health and safety planning.

Action: A note of thanks will be sent to Dr. Caldwell. And for the reasons set forth in his excellent report, a request will be made to the Governor that, in view of the service medicine is prepared to render, a physician be appointed to the Advisory Committee on the Health and Safety of Workers and/or to its smaller replacement rule-making board.

AMA COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

The President appointed Morris H. Saffron, M.D., Vice-Chairman of the Committee on Medical Education, as the Society's official representative to the Council meeting in New York City on June 24, 1961. Dr. Saffron agreed to attend. This was approved. Dr. Saffron will be reimbursed for expenses incurred in attending the meeting.

HOSPITAL RESIDENTS

Three communications on this subject were received and considered: (1) The Chief of Surgery of the Burlington County Hospital requested clarification of the State's attitude concerning the memorandum by the State Board of Medical Examiners informing them "that the provision of the Medical Practice Act . . . which relates to the resident medical staff, will be enforced." This would mean that unlicensed physicians may serve a maximum of only two years as residents. (2) New Jersey Hospital Association Board of Trustees adopted a resolution calling for a change in the provision of the law and offering the assistance of the Association to the State Board of Medical Examiners and The Medical Society of New Jersey in bringing about such an amendment. (3) In reply to the Board's request that the State Board of Medical Examiners be encouraged to sponsor amendatory legislation concerning hospital residents the following proposed amendment was received from the State Board:

R.S. 45:9-21 d. Exempted will be a person while actually serving as a member of the resident staff of any legally incorporated charitable or municipal hospital or asylum approved by the board. Hereafter such exemption of any such resident physician shall not apply with respect to any individual after he shall have served as a resident physician for a period *not to exceed five years.*

Action: The proposed amendment is approved. It is recommended that the proposed amendment be introduced as an administrative measure as soon as possible, with the Medical Society doing all it can to effect its passage.

BOND ISSUE FOR STATE INSTITUTIONS

In a letter from the President of the Board of Control of Institutions and Agencies, Dr. Buchanan, as President of the Medical Society, was invited to serve on the Sponsoring Committee for the proposed bond issue of $40,000,000 to provide new buildings for state institutions. The money is needed for additions and/or replacements. The Sponsoring Committee is bi-partisan. The proposal will be on the November ballot.

Action: The President was authorized to accept the invitation to serve on the Sponsoring Committee.

STATE BOARD OF MEDICAL EXAMINERS

The term of Dr. Edward H. Albano on our State Board of Medical Examiners will expire this summer. The Trustees approved the following suggestions to the Governor for nomination to the Board, the order of preference being as indicated: (1) Dr. Edward H. Albano of East Orange; (2) Dr. George L. Erdman of Summit; and (3) Dr. Raymond H. Taylor of Lakewood.

EXAMINATION OF SCHOOL CHILDREN

In a communication to the State Department of Education, Dr. Jennings—chairman of the Special Committee on Child Health and the Society's official liaison representative to the Department—requested, pending Board action, that the Society's endorsement of the revised "Recommendations" be withheld. In the revision, the section indicating that the examinations may be done by the family physicians had been deleted. Since, by S-66, efforts are being made by the Society to amend the present law to permit school child examination by the family physician, and since such a change is desirable, it is inconsistent that the Medical Society endorse the revised "Recommendations."

Action: Endorsement will be withheld.

MEDICARE RENEWAL CONTRACT

In accordance with the Board's authorization at the re-organization meeting the Medicare renewal contract, with the approval of the fiscal agent, MSA, has been signed by the proper officials and returned to Washington.

CLASSIFIED TELEPHONE LISTINGS

The Camden County Medical Society is voting on a group listing in the classified section of the telephone book, which, if approved, may appear under the heading of "Camden County Medical Society." Since the adjacent county members (Burlington and Gloucester in particular) may desire to be listed, it has been suggested that the listing may be headed by either "The Medical Society of New Jersey" or the "American Medical Association" or both. Written consent to head the listing "The Medical Society of New Jersey" and possible use of a seal were requested.

Action: Authorization is given to the Camden, Gloucester, and Burlington County Medical Societies to use the name and official Seal of The Medical Society of New Jersey in the yellow pages of the telephone directory, without cost to the State Society; upon request this authorization will be extended to any other component society.

AUXILIARY PROGRAM, 1961-62

The proposed program for the Woman's Auxiliary for 1961-62—the same as that of 1960-61, plus the following new items—was approved:

Health Careers: To serve on the Editorial Committee, to aid in the compilation of the "Health Careers Guidebook." Also to conduct a survey to determine the number of members of senior Future Nurses' Clubs who entered schools of nursing or allied health fields in 1960 and 1961.

Program: In collaboration with the Executive Board, to prepare programs for meetings of that body in furtherance of goals or priority projects named by the President.

To distribute (to each county president and program chairman) State Society approved package program material made available after the Post National Convention meeting in late June in New York City.

To present at county level, with county medical society approval, planned programs having teaching or guidance value for more effective community activity.

In conjunction with county medical society committee and other auxiliary chairmen, to encourage study groups to furtber understanding and sociability.

Public Relations: To continue educational programs for Auxiliary members, to maintain an informed auxiliary—collectively and individually—on health subjects and the medical profession.

KING BILL HEARINGS

A letter was sent to the chairman of the House Ways and Means Committee soliciting permission for the Society to submit a statement of its position with reference to H.R. 4222, the King Bill (as was done in connection with the Forand Bill hearings) for inclusion in the record of the Committee.

Action: This was approved.

Kellogg Grant to Rutgers

A million dollar grant by the W. K. Kellogg Foundation will aid our State University in establishing a program in medicine and biology.

The program will provide the first two years of the medical curriculum, with the expectation that the students will transfer to four-year medical schools for junior and senior years. There are nearly 1,000 openings annually in both the third- and fourth-year classes of the nation's medical schools. Some patient care is involved in the two-year medical program, and New Brunswick's hospital facilities can meet this need.

Since 1960, the Kellogg Foundation has aided the establishment or the expansion of four of these two-year programs at the universities of Connecticut and New Mexico, at Dartmouth, and now in New Jersey.

Do You Have a Paper for the Next Annual Meeting?

The Committee on Annual Meeting and various section chairmen want the program to represent real membership participation. So, if you have any ideas about the content of the program for any section, notify the Executive Offices. If you have a paper of your own, send the data to the Annual Meeting Committee, care of Executive Offices, The Medical Society of New Jersey, Box 904, Trenton 5, N. J. The committee will want to know the title and subject of the paper, the time you would need to present it, whether you will need lantern slide, moving picture, or blackboard facilities, and in what Section the presentation would seem most appropriate.

Obituaries • • •

DR. GEORGE BLACKBURNE

A half century of service to the people of Essex County was terminated on June 17 with the death that day of Dr. George Blackburne. Born in Newark in 1885, he was graduated from Bellevue in 1907. He took a two-year internship in the old Newark City Hospital and entered private practice in 1909. The following year, he became a staff assistant at St. Michael's Hospital in Newark and worked through all grades of service there, becoming president of the medical board in 1934. He also worked at Newark Presbyterian Hospital, becoming chief of surgery there in 1950. Dr. Blackburne had staff appointments at many other hospitals, too. In 1937 he became president of the Society of Surgeons of New Jersey. A decade later he was president of our Essex County Medical Society.

Dr. Blackburne served as president of the Newark Lions' Club. He was commander of an American Legion Post. His Army career extended, with some interruptions, from 1911 to 1920, from private in the cavalry to major in the medical corps. He was commanding officer of an army hospital in occupied Germany in 1919 and 1920. He was active in Blue Cross, and served several years as a Trustee of Hospital Service Plan. He was also active in the New Jersey Academy of Medicine.

DR. ROWLAND P. BLYTHE

Death came on June 18 to Rowland P. Blythe, a distinguished Union County obstetrician. He was born in upstate New York in 1891 and he earned his M.D. at Cornell in the class of 1915. After a general internship at Bellevue, he won a surgical residency there. After completing this, he became an Army surgeon, serving in France and later, with the Relief Foundation, in Armenia. He then came to New Jersey, serving first as a school physician in Cranford. Later he specialized in obstetrics, eventually becoming an attending or consulting obstetrician at several hospitals in Union County. It is estimated that Dr. Blythe delivered 10,000 babies in 40 years (about 250 a year!). Dr. Blythe served as president of the Union County Medical Society and was an F.A.C.S.

DR. WILLIAM S. DAVIS

After serving the people of Essex County for almost half a century, Dr. William J. Davis died of a heart attack on July 26.

Born in 1891 in upstate New York, Dr. Davis earned his M.D. at the Medical School of New York University in 1919. After interning at Flower Hospital in New York City he came to the Essex County Hospital in Belleville in 1920 and then, after a residency there, he opened an office for private practice in East Orange. Dr. Davis was a general practitioner with staff affiliations at the Orange Memorial and Presbyterian Hospitals. He was a fine singer and for years was a member of the Doctors' Chorus of the Essex County Medical Society.

DR. LOUIS HILTON

Dr. Louis Hilton, a Newark physician for over forty years, died on July 19. Born in Newark in 1890, he was graduated from the Medical School of Howard University in 1910. After interning in West Virginia and doing general practice there, he entered the Army in 1917. He served overseas with the American Expeditionary Forces and in 1919, on being mustered out, set up an office in Newark. He served the people of Newark consistently since 1919.

Dr. Hilton was a city physician for many years. He was an examiner for the New Jersey Athletic Commission and active in committee work in the Essex County Medical Society. He was a leader in civic affairs in many aspects of life in Newark.

DR. CHARLES B. KELLEY

Dr. Charles B. Kelley, one of Hudson County's leading gynecologists and obstetricians, died on July 26 at the age of 75. A native of Jersey City, he received his medical degree from New York University and did graduate work in George Washington University and in Austria. Dr. Kelley was dynamically active in civic and administrative affairs in New Jersey medicine. He served as secretary and later as president of the New Jersey State Board of Medical Examiners. He was also an executive of the Federation of Medical Boards of the United States. He had a tour of duty as treasurer and later as president of the Hudson County Medical Society. He was on the staff of most of the hospitals in Bergen and Hudson Counties. He was a charter member of the Aesculapian Club, and was an extensive contributor to the medical literature. His wife was the director of nurses at the Jersey City Medical Center and his daughter was an opera librettist with the Metropolitan Opera House.

DR. WILLIAM H. McCORMICK

Dr. William H. McCormick, a medical officer of the Public Health Service and a former Perth Amboy practitioner, died on July 6. Born in Perth Amboy in 1885, he was graduated in 1911 from the medical school of the University of Pennsylvania. After interning at St. Francis Hospital in Trenton, he worked at the State Village in Skillman until the outbreak of World War I, when he served as a captain in the Medical Corps. Thereafter he returned to his native city and entered private practice. For 40 years he was a Perth Amboy school physician. He served the Perth Amboy General Hospital from 1930 to 1950, eventually becoming attending surgeon there. He had a tour of duty as president of the Middlesex County Medical Society and in 1949 was chief of staff at the General Hospital.

DR. CHARLES E. McWILLIAMS

At the age of 66, Dr. Charles E. McWilliams died suddenly on June 30. A graduate of the Jefferson Medical College (class of 1920), Dr. McWilliams entered private practice in Blackwood and served the people of South Jersey for 40 years. He was chairman of the Gloucester Township Board of Health and had long service as Township Physician. He was active in the affairs of the Camden County Medical Society. Dr. McWilliams was a well-known participant in South Jersey civic affairs—the Kiwanis Club, the Committee for Underprivileged Children, the Fire Company and many others.

DR. ERNEST W. RICHARDS

Born in Bermuda in 1901, Dr. Ernest W. Richards died in Paramus, N. J. on July 3. A 1933 graduate of Howard Medical School, he interned at the Philips Hospital in St. Louis. He then came to Bergen County where he established an active general practice. He was a member of the Bergen County Medical Society and took part in numerous civic and fraternal affairs in the Hackensack area.

DR. VINCENT J. RIGGS

Death came at the age of 54 to Vincent J. Riggs, one of the state's best known neuropsychiatrists. Born in Jersey City, he was graduated in 1930 from the medical school of St. Louis University and interned at Christ Hospital in Jersey City. He had a year's residency in internal medicine at the Jersey City Medical Center before deciding to devote himself to psychiatry and neurology. In 1932 he became a member of the staff at Greystone Park and in 1941 he entered private practice in his chosen specialty, in East Orange. He won staff appointments at the Orange Hospital Center, at Presbyterian Hospital and at St. Barnabas Hospital in Newark. He was active in the affairs of the New Jersey Neuropsychiatric Association and in the Essex County Medical Society. Dr. Riggs died on July 4.

DR. CHARLES STAHL

Dr. Charles Stahl, age 64, died on June 17 after a short illness. After graduating in 1922 from the medical school of Cornell University, he interned at the Newark City Hospital and then opened an office for private practice in Newark. He was appointed to the staff of the Presbyterian Hospital where he served for many years in the general practice section. He was a longtime member of the Essex County Anatomical and Pathological Society and was active in the affairs of the Academy of Medicine.

DR. LEONARD TROAST

At the untimely age of 45, Dr. Leonard Troast died on June 18 following an attack of coronary thrombosis. Born in Passaic, he received his MD in 1943 at Bellevue. After interning at Bellevue, he entered the Navy and served as a medical officer in the Pacific. He then came to Jersey City where he devoted himself to internal medicine and, subsequently, to gastro-enterology. He was a diplomate in internal medicine, a Fellow of the American College of Gastro-enterology, a teacher at Seton Hall, and a consultant at St. Francis Hospital in Jersey City. Dr. Troast was attending gastro-enterologist at the Jersey City Medical Center. He was active in the affairs of the Hudson County Medical Society.

DR. BERTA WHALAND

One of Cumberland County's best known physicians, Dr. Berta Whaland died on July 7. Born in Pennsylvania in 1885, she received her M.D. in 1910 from the Women's Medical College of Philadelphia. Earlier, she had been a pharmacist (having won her Ph.G. from the Philadelphia College of Pharmacy in 1906) and for some years operated a drug store in central Philadelphia. In 1919 she moved across the river to Bridgeton and served the people of South Jersey for 41 years thereafter. She specialized in otology and laryngology. Dr. Whaland in 1960 received a special accolade from her alma mater, and last summer was one of our Golden Merit Award winners.

Announcements

Attention: Flying Physicians

The Flying Physicians of New Jersey will have a fly-in in Atlantic City during the September 23 weekend. The convention is at the President Hotel on the Boardwalk. Physicians will then tour the facilities of the National Aviation Experimental Center. For details write to Dr. James Garofalo at 135 Smull Avenue, West Caldwell, N. J.

Sunday Seminars on Metabolism

From October 8, 1961 through May 10, 1962 a seminar will be held on the first Sunday of each month at the Monmouth Medical Center on Pavilion Avenue in Long Branch at 11:00 a.m. All aspects of metabolism and nutrition will be covered. There is no tuition fee.

For detailed program, write to the Director of Medicine, Monmouth Medical Center, Pavilion Avenue, Long Branch.

Diabetes and the Liver

The Mountainside Hospital in Montclair will be the scene of the Ninth Annual Symposium of the New Jersey Diabetes Association. This year's program is devoted to "Diabetes and the Liver." The meeting starts promptly at 2:00 p.m. and terminates at 5:00 p.m. on Wednesday, October 25. For details write to Dr. Otto Brandman at 558 Prospect Street, Maplewood, N. J.

Genetics in Psychiatry

On Friday and Saturday, October 27 and 28, a symposium will be held on "Genetics in Psychiatry" in the 8th floor auditorium of The Psychiatric Institute, 722 W. 168th Street, New York City. This is an outstanding and unique program and all readers of this JOURNAL are welcome to attend. For more details, write to Dr. Wilfred Dorfman, 1921 Newkirk Avenue, Brooklyn 26, N. Y.

Symposium on Electroencephalography

On Wednesday morning, September 27 at 9:30 a.m. a symposium will be held at the New Jersey Neuro-Psychiatric Institute in Princeton on electroencephalography. This is sponsored by the New Jersey State Department of Health and the New Jersey Department of Institutions and Agencies, with the professional approval of the New Jersey Psychiatric Association. The program is designed for both neurologists and EEG technicians.

For details write to Dr. Robert E. Bennett, P. O. Box 1000, Princeton, N. J.

Recent Advances in Medicine

Every Wednesday afternoon from October 18 through December 6 a graduate course will be given on Recent Advances in Internal Medicine. Sponsored by Temple University and administered by a star-studded faculty, this will review up-to-date practices both for the internist and the general practitioner. The fee is $50. American Academy of General Practice will give credit for attendance.

For details write to Department of Medicine, Temple University Medical Center, Broad and Ontario Streets, Philadelphia 40, Pa.

Lecture on Histamine

New York University announces the tenth Sigmund Pollitzer Lecture on Friday, October 13, 1961, at 3 p.m., in Alumni Hall, 550 First Avenue, New York City.

The guest lecturer, Dr. Bernard N. Halpern, is professor of experimental medicine in the College de France in Paris. The title of his talk will be, "Histamine, an Old and Still a New Problem."

The Pollitzer Lectures are made possible by a grant from Mrs. Sigmund Pollitzer, who established the lectureship in honor of her husband, the late Dr. Sigmund Pollitzer, former professor of dermatology at NYU.

Alcoholism in Medical Practice

A symposium on Alcoholism in Medical Practice is scheduled for the Philadelphia College of Physicians at 19 South 22nd Street, that city, for the afternoon of October 30, 1961. All aspects of alcoholism for the internist and the general practitioner will be reviewed. The American Academy of General Practice will give credit for attendance.

For details write to the Philadelphia County Medical Society, 301 South 21st Street, Philadelphia 9, Pa.

Conference on the Human Cervix

Announcement is made of a conference December 7, 8 and 9 on the human cervix. Sponsored by the New York Academy of Sciences, the colloquium will be held at the Henry Hudson Hotel, New York City. It will be led by a star-studded faculty. For details, write to Dr. Alfred B. Kupferberg, Ortho Research Foundation, Raritan, N. J.

Medical Essay Contest

The Trustees of America's oldest medical essay contest, the Caleb Fiske Prize of the Rhode Island Medical Society, announce two subjects for this year's dissertation, open to any *doctor of medicine in the nation*. A cash prize of $500 will be awarded. The subjects are: "Recent Advances in the Treatment of Malignant Disease," and "Current Status of Cardiac Surgery." An essay on either subject must be typewritten, double spaced, and should not exceed ten thousand words. Essays must be submitted by December 11, 1961 to the Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Diabetes Symposium

December 1 has been fixed as the date for the diabetes seminar sponsored annually by the New York Diabetes Association. Theme of this year's meeting is "All About Insulin." Dr. Charles Best will attend as guest of honor. The meeting will be held at the Hotel Pierre at Number 1 East 61 Street, New York City.

For details, write to New York Diabetes Association at 104 East 40 Street, New York 16, N. Y.

Course in TB Laboratory Technics

Laboratory personnel—professional and technical—are welcome to participate without fee in a course in laboratory methods in tuberculosis. The course will be given by the U. S. Public Health Service in Atlanta, Geogia, January 15 through February 9, 1962. For further details write to Laboratory Branch, U. S. Public Health Service Communicable Disease Center in Atlanta, Georgia.

Sabin to Speak in New Jersey

On October 15 at 2:30 p.m., the University of Cincinnati's distinguished professor of pediatrics, Albert B. Sabin, will speak in West Orange at the dedication of a new building at the Kessler Institute for Rehabilitation. On this occasion Dr. Sabin will receive the "Dignity of Man" award, accepted in previous years by Robert J. Oppenheimer and Marian Anderson. You are invited to share in this interesting occasion.

For details write to Administrator, Kessler Institute, Pleasant Valley Way, West Orange.

County Society Reports • • •

Burlington

Annual Ladies' Night for the *Burlington County Medical Society* was held at the Riverton Country Club on May 11. A chilling rain discouraged all but the brave from playing golf; however, the remainder of the program was enjoyed by all 86 in attendance. Social hour was followed by a delicious dinner with Joe Conway's orchestra providing dinner music and our own Dr. LeFavor played piano between courses.

Dr. Betsch, as master of ceremonies, introduced the speakers and maintained a smooth operation throughout. President Boudwin summarized the year's activities and pointed out that the 1960 Annual Meeting of the State Society had 100 per cent attendance by our delegates. Dr. R. Winfield Betts was given special commendation for his outstanding work as secretary for the past seven years. The gavel of presidential office was then received by Dr. Ralph VanMeter, our incoming president, with a few words on things to come.

A moment of silence was observed in respect to the memories of Dr. Robert Haldeman and Dr. N. A. Westcoat who had died during the Society year.

Mrs. Keith Young, outgoing president of the Woman's Auxiliary, gave a resume of their activities and introduced their incoming president, Mrs. Thomas McMillan.

The "home-talent" emerged with Dr. Fugate at the drums, Dr. Dean LeFavor, the piano, and Dr. Austin Horan playing the clarinet. Dr. Girton Kinney sang two solos. Dancing followed, so all in all it was truly a fine evening.

JOHN ARBOGAST, JR., M.D.

Reporter

Middlesex

The annual dinner meeting and installation of officers of the *Middlesex County Medical Society* was held at the Pines Restaurant on June 21, at 6:30 p.m. Reading of May minutes was waived to hasten the pleasure of the evening.

On recommendation of the Judicial Medical Ethics Committee, Dr. B. F. Slobodien, Chairman, the following applicants were recommended for election to membership, as follows: To two years' Associate membership: Daniel Fishkoff, Perth Amboy and Charles L. Ravaris, New Brunswick. To Regular membership from two years' Associate membership: Roger J. Madiou, New Brunswick and Joseph Uhrik, Metuchen.

It was stated that the application of Italo J. Falcone, O.D.-M.D., New Brunswick, could now be processed and he could be declared a regular member of the Middlesex County Medical Society by order of the Supreme Court of New Jersey as of May 8, 1961. He was, therefore, declared a member of this Society by mandate of law, in these terms: "The application of Italo J. Falcone, O.D.-M.D., cannot be processed according to the Regulations of the Middlesex County Medical Society's Constitution and By-Laws. But as President of the Middlesex County Medical Society, and having been duly informed of the mandate of the New Jersey State Supreme Court, and respecting the law I, Stanley A. Gadek, M.D., hereby declare Italo J. Falcone, O.D.-M.D., a regular member of the Middlesex County Medical Society by mandate of the New Jersey State Supreme Court dated May 8, 1961.

"I further request that this declaration be spread on the minutes of this meeting and that a copy of this declaration be attached to and become a part of the application for membership of Italo J. Falcone, O.D.-M.D. I remind Dr. B. F. Slobodien, Chairman of the Judicial-Medical Ethics Committee to forward the application and copy of the above declaration to the Credentials Committee of The Medical Society of New Jersey for its attention and action. Also, Dr. Donald T. Akey, Secretary, will forward a letter to Mr. David Wilentz forthwith informing him that Italo J. Falcone, O.D.-M.D., became a regular member of the Middlesex County Medical Society by mandate of the New Jersey Supreme Court, by action of the County Medical Society, June 21, 1961. A copy of this letter should also be sent to Italo J. Falcone, O.D.-M.D."

The following were elected and installed for 1961-62: President—Dr. Thomas F. McLaughlin, Metuchen; Vice-President—Dr. Ralph E. Siegel, Perth Amboy; Secretary—Dr. B. Friedenthal, New Brunswick; Treasurer—Dr. Eugene J. Tyrrell, Perth Amboy and Recorder—Dr. Eugene L. Childers, Edison. Board of Trustees: Dr. Stanley A. Gadek, Chairman and Drs. Charles H. Calvin, Malcolm M. Dunham, George J. Kohut, Charles Gandek, Joseph F. Sandella, John A. Smith, A. Marshall Smith, Sr. and Benjamin F. Slobodien. Judicial-Medical Ethics Committee for three years: Dr. B. F. Slobodien, Chairman and Drs. Donald T. Akey and George T. Henderson. Delegates and Alternates to The Medical Society of New Jersey for three years: Delegates: Drs. F. M. Clarke, Sr., A. Fishkoff, S. A. Gadek, G. J. Kohut and John A. Smith; Alternates: F. S. Taber, R. C. Steinman,

V. J. Cannamela, M. B. Jacobson and Howard Joselson.

Guests of the evening were introduced by Dr. John A. Smith. Dr. Jacobson introduced Dr. and Mrs. Goldstein from Israel, both of whom are physicians.

Dr. Stanley A. Gadek, in his parting speech, gave us the highlights of his leadership during the past year. Those being: (1) Settlement of the Falcone Case by the State Supreme Court; (2) The honor of having Dr. Charles H. Calvin elected to the second vice-presidency of The Medical Society of New Jersey; (3) Presentation to Carolyn M. Kidd of a check in appreciation for her twenty-five years of devoted service; (4) Organization of a joint bar and medical meeting in which Judge Smith gave a very interesting talk on the impartial medical witness; (5) An unusual symposium on air pollution, and (6) Stimulating the attendance by the installation of a new telephone system at Roosevelt Hospital and the adoption of the question and answer system at meetings.

In parting, Dr. Gadek reminded us that we are men born to obligations from which we cannot escape. "We are servants of Society but should never allow ourselves to become slaves of Society."

President Thomas F. McLaughlin was then presented. In his acceptance address, a warning was given to formulate a plan against the present Administration's effort to institute socialized medicine for the aged.

The out-going president, Dr. Stanley A. Gadek, was then presented a plaque.

Jacquelyn M. Childers, president of the Woman's Auxiliary, was introduced.

The evening was then concluded with dancing and entertainment.

EUGENE L. CHILDERS, M.D.
Reporter

Book Reviews

Blood Diseases of Infancy and Childhood. Carl H. Smith, M.D. St. Louis 1960. Mosby. Pp. 572 with 51 illustrations. ($17.00)

Admittedly, there are large gaps in our knowledge of hematology. An attempt is made to fill in these gaps in this text. It is remarkably up to date and detailed in its information although managing to be concise.

A background is provided early in the book which considers normal embryologic development and its aberrations together with blood changes during early growth. There follows interpretation, diagnosis, and management of the blood diseases encountered in pediatric practice. New and interesting are the hereditary bases of blood diseases and maternal and fetal interaction and the importance of the placental physiology in the transmission of antibodies, isoagglutinins, and the L. E. Factor.

An excellent consideration of childhood hematology follows, including blood grouping, transfusions, jaundice in the neonatal period, erythroblastosis fetalis, the hereditary hemoglobinopathies and child leukemia. There are other chapters devoted to the anemias, the purpuras, blood coagulation, and the factors involved.

The bibliographic references are to recent literature. Illustrations are superior. Altogether, this is an excellent hematology reference work for practitioners.

RALPH N. SHAPIRO, M. D.

Beloved Professor: Life and Times of William Dodge Frost. By Russell E. Frost, M.S. New York, 1961. Vantage Press, Inc. Pp. 350. ($3.75)

This biography of a pioneer American bacteriologist provides an interesting account of the long and useful life of a remarkable American. Written by his son in a conversational style, the book makes good reading, is technically attractive and indexed.

Of New England ancestry, Frost was the son of an apothecary who moved west from Maine with his courageous wife. Their son, William, was born on a farm in Minnesota in 1867. At the age of ten he moved with the family to Marshall, Minnesota, near the Dakota border. Prairie life there was of the pioneer sort. Frost worked his way through college, taking a B.S. degree in botany from the University of Minnesota in 1893, and M.S. the following year. Graduate study at Johns Hopkins University in 1900 brought him into contact with great figures of American medicine, Drs. William H. Welch and William Osler, among others. He received a Ph.D. degree at the University of Wisconsin (1903), and Dr. P.H. from Harvard (1913). At Harvard, he was a student of Dr. Milton J. Rosenau, first professor of preventive medicine in the United States. Returning to Wisconsin, Dr. Frost became professor of bacteriology, continuing an academic career begun as assistant in bacteriology in 1895.

Frost became a pioneer in the fight against tuberculosis in this country; in this role he was inspired by contact with Drs. Robert Koch, Edward L. Trudeau and Selman A. Waksman.

Professor Frost was also a leader in milk bacteriology and contributed much to the production of a clean and wholesome milk supply. He served a term as president of the American Association of Medical Milk Commissions in the 1930's. He was an early champion of the concept of antibiosis. Associates of Dr. Frost in scientific progress included Drs. E. L. Hewitt of Minnesota, E. B. Fred, H. L. Russell and William S. Middleton of Wisconsin, Victor Vaughn and Frederick Novy of Michigan, Arthur L. Kendall of Princeton, and other outstanding figures in American microbiology.

Frost wrote ninety scientific articles and several textbooks—one a monograph titled *The Streptococci*, co-authored with Dr. Mildred A. Engelbrecht in 1940. An inventor, too, he devised an auxanometer for measuring day-by-day growth of plants, the Frost gasometer for measuring bacteriologic gas production, the Frost Little plate method for counting live bacteria in milk, and many other useful devices. His death in 1957 ended a career full of years and honor.

His son, Russell E. Frost, followed the illustrious father in agricultural and dairy bacteriology. As biographer, he was fortunate to have the assistance of the "beloved professor" in the preparation of this valuable and readable book.

Fred B. Rogers, M.D.

The Question of Fertility. By Georges Valensin, M.D. First Edition in the United States of America. New York 1960. Doubleday. Pp. 296. ($4.50)

This book presents a rare combination of charm, wit and medical facts. Written by a French gynecologist it was recently translated into English. It offers an excellent coverage of the question of fertility from every conceivable aspect. Dr. Valensin discusses in concise form such little thought of aspects as, the undesirable husband, the effects of light on sterility, the best hours for procreation, and the effect of baths on fertility. Other topics like overweight, vitamins, tobacco, alcohol are presented with a sound evaluation of their effects. Only a French author could handle so well the subject of the sexual revival of the monogamous husband or stimulation of fertility by "strangers". Throughout this work there is an ever present air of charm and humor. At times, the reader feels the author has his tongue in his cheek as he points out the obvious, but seldom discussed factors that can affect fertility. Legal, religious, financial, historical and mechanical aspects are dealt with systematically and frankly. This book is one which could be enjoyed equally by the family physician, the neurosurgeon, or the gynecologist.

Victor Huberman, M.D.

A Doctor in Many Lands. By Aldo Castellani, M.D. Garden City, N. Y., 1960. Doubleday. Pp. 359. ($4.95)

Dr. Castellani is generally credited with discovering the role of the trypanasome and tsetse fly in African sleeping sickness. He was at one time personal physician to Mussolini (a good man, he assures us, who was corrupted by Hitler) and surgeon-general of the Italian army during its war on Ethiopia in 1935. This book is the autobiography of one of the best experts in tropical medicine in modern times. It includes factual material on the control of tropical diseases, particularly under military conditions. Dr. Castellani is quite a name-dropper—Rudolph Valentino, Lord Beaverbrook, Benito Mussolini, Paderewski, Rommel, Sun Yat Sen and many others are seen here, some with their pants down. As the book has no index you have to read the whole volume to locate these famous names. The book is well written and holds the reader's interest.

Henry A. Davidson, M.D.

Diseases of the Newborn. By A. J. Schaffer, M.D. Philadelphia 1960. Saunders. Pp. 878, illus. ($20.00)

This is the best book on neonatology available. The words "Neonatology and Neonatologist" indicate the emphasis pediatricians may place on this phase of their training and practice in the interests of conquering this "Last Frontier:" the saving of infant life. The implication that a subspecialty may thus be established opens the question of fractionating the pediatric patient into separate segments related to age groups. Most of us are opposed to this concept at present, but not to the philosophy implicit in this excellent reference work—better knowledge of the neonate.

The section dealing with resuscitation in the delivery room and the proper setup and principles of full term and premature infant care in nurseries cannot be improved upon.

The disorders of the various newborn organ systems are well treated though not outlined. The clarity and organization of subject matter demonstrated by the author might be utilized sometime in the future on some topics which by the author's admission were not to be discussed in this text. More elucidation might have been offered to such subjects as allergy, in the neonate; the emotional and social factors affecting the homes and parents in which these infants reside; the reconstructive surgery as well as the pre- and postoperative management.

An essential decision was boldly made to stress treatment (which can be ascertained elsewhere). This leaves more space for discussion of diagnosis rather than to offer lengthy discussion of signs and symptoms and for concise documentation of case material; it makes the book a better diagnostic reference.

The section on "neonatal cardiology" by Dr. Markowitz is a splendid review of the author's experience and of the literature. Pediatricians are well aware of the difficulties in the diagnosis of cardiac problems in the neonate. Dr. Markowitz has organized the important clinical, radiographic and electrocardiographic cues to yield a more accurate diagnosis of congenital heart disease in the newborn. Case histories are amply illustrated. This section is not limited to congenital heart disease. It includes a nice description of myocarditis, cardiac arrhythmias, and other cardiovascular conditions of the newborn. Separate chapters are devoted to the general manifestations of neonatal heart diseases and treatment; these are very useful for an overall, rapid review by the reader in pinpointing diagnostic criteria in cardiac abnormalities or disease of the newborn.

The bibliography is adequate without being weighty. This book should be on all medical library bookshelves. The reviewers heartily recommend its use by any physician responsible for the care of the newborns.

EDWARD P. DUFFY, M.D.

MILTON PRYSTOWSKY, M.D.

Haemopoiesis. Cell Production and Its Regulation. Edited by G. E. W. Wolstenholme, M.D. and Maeve O'Connor, B.A. Boston 1960. Little, Brown. Pp. 490, illus. ($11.00)

This volume is an account of the 60th Ciba Foundation Symposium on Haemopoiesis. The text includes a series of lectures followed by a summary and an edited general discussion. Materials presented include the lymphoid myeloid complex; the use of tritiated thymidine in the study of haemopoietic cell proliferation; investigation of the lymphoid myeloid system in thymectomized rats; production and distribution of granulocyte release; humoral influences on blood formation and release; the properties of urinary erythropoietin and transfusion induced polycythaemia as a model for studying factors influencing erythropoiesis.

In general the conference discussed the question of a multi-potent stem cell and its relationship to survival following exposure to radiation. Models of haemopoietic cell proliferation were investigated. It was stated that in the smaller laboratory animals the life of the circulating red cell is shorter than it is in man. The lymphoid content of the thoracic duct lymph tends to vary inversely with the size of the animal. The value of tritiated thymidine as an excellent tool for studies of cell formation, life span and fate was extolled. Some of the workers felt that the developmental sequence of lymphocytes was from large to medium to small.

Despite some dissenting opinions, hypoxia regardless of type, appears to constitute the fundamental erythropoietic stimulus which is mediated to myeloid reticulum by humoral factors. The thermo-stable, ether-soluble factor which affects cell division appears to be lipid. The factor which enhances hemoglobin synthesis is a mucoprotein.

This book is valuable to those interested in anemia, radiation injuries and advanced technics pertaining to the study of such conditions. The Ciba Foundation is to be congratulated on bringing together and recording the discussions of such a brilliant group of advanced students of haemopoiesis.

T. K. RATHMELL, M.D.

Lose Weight and Live. Robert P. Goldman. Garden City, 1961. Doubleday. Pp. 236. ($3.95)

This reviewer, an ex-fat man, read this witty volume with considerable interest. Mr. Goldman insists that food control is a relatively minor part of losing weight, and he does not think much of elaborate calorie calculus. Instead, he puts his trust in motivation. While most of us think that vanity is a more potent motive than fear, Mr. Goldman disagrees. He suggests that the fat man or woman will make up his mind to lose weight when properly motivated; that one motivating factor is information, another is fear—as when seeing a fat friend die of a coronary. There is an interesting chapter by Mrs. Goldman on how to help your husband lose weight. The author attaches more importance to exercise than most of us do. The text is made more palatable by some whimsical cartoons from the pen of Roland Rodegast. The book is salted by some practical pointers and the author leans heavily on medical authority for his statements about body physiology. The physician will find here some ideas for talks on the topic to lay audiences.

ADIPOSITY ANONYMOUS

Handbook of Medical Treatment. By M. J. Chatton, S. Margen and Henry Brainerd. Los Altos, California 1960. Lange Medical Publications. Ed. 7. Pp. 571. ($3.50)

Since it was first issued in 1949, this handbook has been exceedingly well received. It will fit into an overcoat pocket—it's not really a vest pocket manual, of course. The volume lists all common medical disorders, with the recommended therapy spelled out concisely and precisely. The book is salted with many practical tables such as emergency drugs, normal blood values, bed positions, electrolytic balance data, and many diagnostic tabulations. It is a wonderfully compact little volume, and should be a life-saver to the busy doctor (in one sense of that phrase) as well as to the patient—in another sense. This seventh edition brings it right into the middle of 1960.

ULYSSES M. FRANK, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

SEPTEMBER, 1961 • VOL. XXXIV, No. 7

RESUSCITATION OF THE MORIBUND ASTHMATIC AND EMPHYSEMATOUS PATIENT

Mechanical means of treatment are called for when patients are near death from bronchial obstruction. Ventilation can be induced by a manually operated portable resuscitator, followed by procedures to draw out viscid mucus.

The increasing awareness of a relatively high mortality in severely asthmatic and emphysematous patients, whether due to a better understanding of the pathophysiology involved or to a changing character of the disease, appears much more realistic than the attitude of ten years ago when death from an attack of bronchial asthma was considered rare.

In a three-year period, while an anesthesiologist at a 275-bed general hospital of a medium-sized city, I was consulted in the emergency treatment of five moribund patients —three in status asthmaticus and two with advanced pulmonary emphysema. All these patients were considered moribund by the attending internists, that is, they were expected to die within a matter of minutes. They were either unconscious or semicomatose, with severe cyanosis and in marked hypoventilation.

PRECONCEIVED APPROACH

These five consecutive cases were successfully treated by means of resuscitative procedures. The importance of a preconceived and active approach in this emergency situation must be emphasized. The technical details of the method of resuscitation are simple and within the scope of every practicing anesthesiologist. The basic equipment is modest and should be readily available in every hospital. Decisive use of these available skills and devices may be of benefit to many moribund patients with obstructive hypoventilation.

In two of the cases, ventilation was started with bag and mask. A mixture of oxygen and helium was used in one case and oxygen alone in another. In the other three cases, a bellows-type Kreiselman resuscitator was employed, using room air only.

After ventilation had been started, in each case an endotracheal tube was inserted by the nasal route and suctioning of the tracheobronchial tree was alternated rapidly with ventilation. In the last two consecutive cases, the tube was connected with a Bennet respirator during the recovery phase to maintain normal breathing.

Drugs used with the mechanical measures were theophylline ethylenediamine, hydrocortisone, and epinephrine. Aerosols were also used in two cases.

Stripped of any incidental element, the principle of the method is a mechanical one, that is, the prolonged use of the suction-ventilation cycle to overcome the obstructive crisis. Although bronchial asthma and pulmonary emphysema are complex diseases, a purely mechanical problem is involved in the terminal phase.

Psychosomatic and allergic factors, bronchospasm, infection, organic changes of the

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KURT O. LEONHARDT, M.D., *New England Journal of Medicine*, April 20, 1961.

bronchi and alveoli, disturbances of the ratio of ventilation to blood flow and a decreased diffusing capacity all play their parts in the natural history of the process. However, at the time of the crisis the many aspects are reduced to the clinical picture of generalized obstructive hypoventilation. This change appears when the work of breathing exceeds the limits of compensation and large amounts of viscid mucus begin to accumulate. Respiratory acidosis and anoxemia increase rapidly and add central-nervous-system depression to the failure of pulmonary respiration. These cases have advanced beyond the reach of drug therapy. A mechanical means of treatment is called for to cope with a mechanical cause.

RESPIRATOR A HELP

The use of a well-constructed respirator can be of great help in the recovery period after the mechanics of breathing have been normalized to the extent of complying with the physical characteristics of the machine. It guides the patient through the critical hours, guarding against the ever-present danger of a relapse. It also provides for intensive aerosol therapy, with bronchodilators, antibiotics, and detergents being used as necessary.

The danger of rupturing alveoli by positive pressure applied to the airways is overrated in general and especially in patients with severe obstruction. The rigidity of the muscles, the very high resistance in the airways, and the generalized nature of the obstructive process are the reasons that high inspiratory pressure of a short duration is not only tolerated but also required for good results. Occasionally, however, this complication may constitute a calculated risk, and equipment for decompression of a tension pneumothorax should be available. By the same token, the presence of an intrathoracic pneumothorax or of mediastinal emphysema is a contraindication to the use of any positive-pressure method.

A second possible danger of high-pressure ventilation is impairment of venous return and a fall of cardiac output. This is especially true for patients with a low blood volume or capillary damage. In the present study, no marked cardiovascular effects were observed despite advanced cor pulmonale in three patients.

DRUG THERAPY NOT EXCLUDED

This emphasis on the mechanical aspects does not exclude drug therapy when an adequate response can be expected. This is true in the prevention of a crisis and in the recovery phase and always for treatment of an intercurrent or superimposed infection. All the patients received systemic antibiotics and one was treated intensively with penicillin aerosol. Furthermore, drugs must be used when any additional indication is present such as heart failure, prolonged hypotension, and overdosage of narcotics.

In all cases the question of performing a tracheostomy in the recovery phase was given careful consideration. However, since none of the patients required endotracheal intubation for more than 18 hours and since ventilation and evacuation of mucus were well under control at the time of extubation, a tracheostomy was not considered necessary. If there is any doubt, one should not hesitate to use this procedure.

The duration and severity of the underlying pulmonary disease is of importance in determining factors that may have contributed to the development of an obstructive crisis.

A last but most important aspect of prevention is the time factor. In all cases in the series there was a substantial delay ranging from 30 minutes to 24 hours before the ineffectiveness of drug treatment was recognized and more adequate help called for. If the possibility of this catastrophe is sufficiently appreciated, an early diagnosis of drug resistance and the prompt availability of a well-established plan of action should save valuable time.

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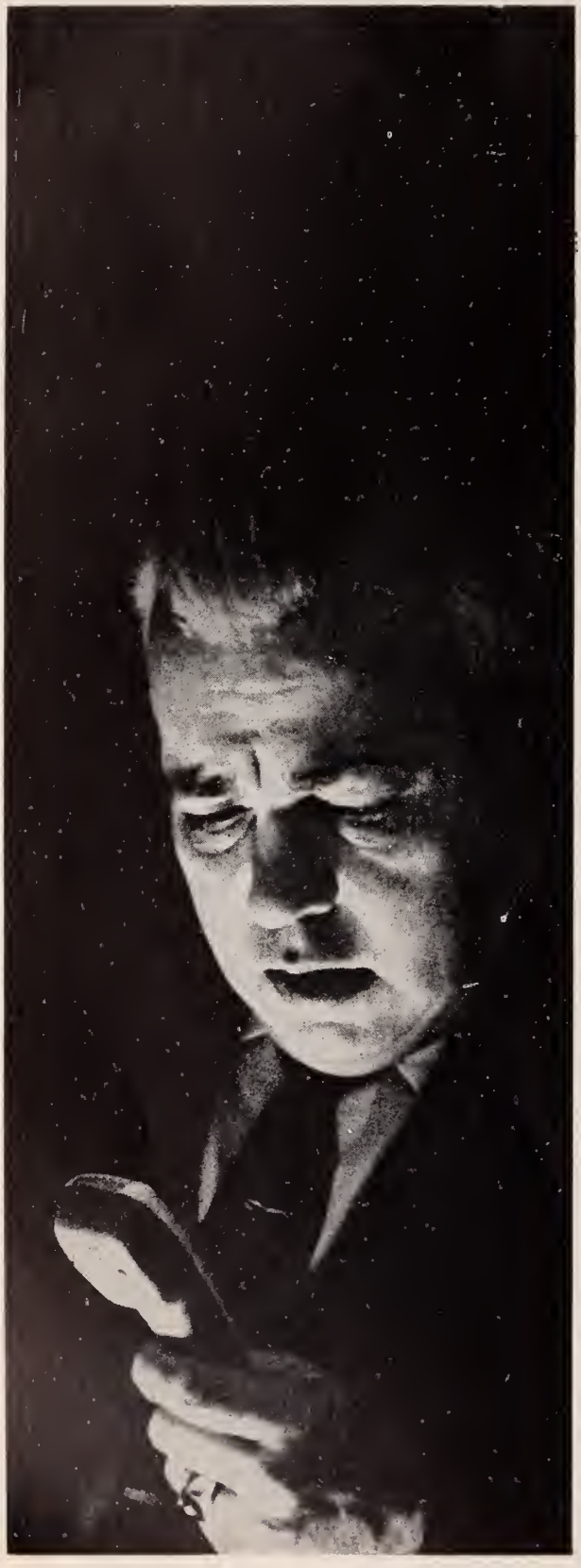


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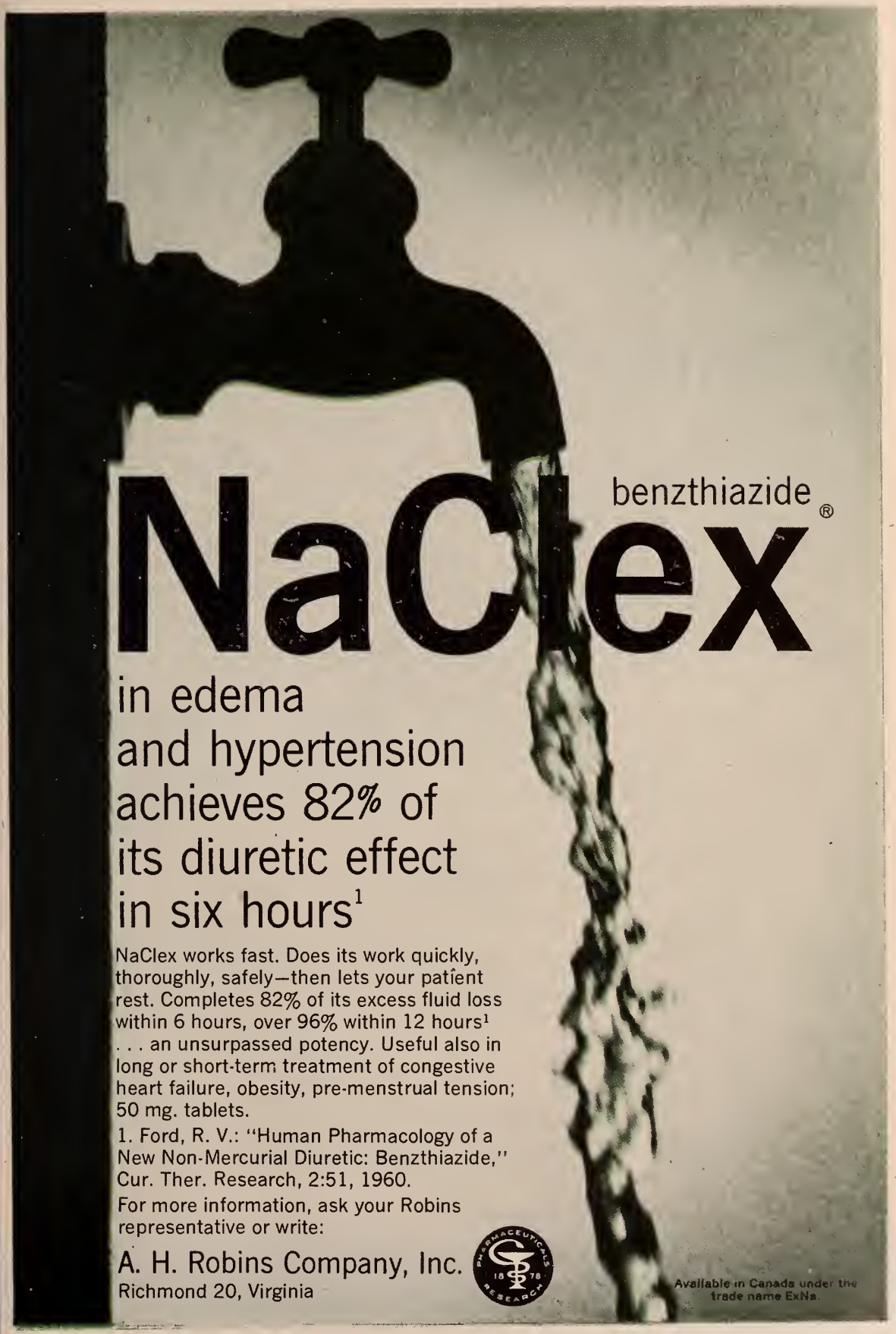
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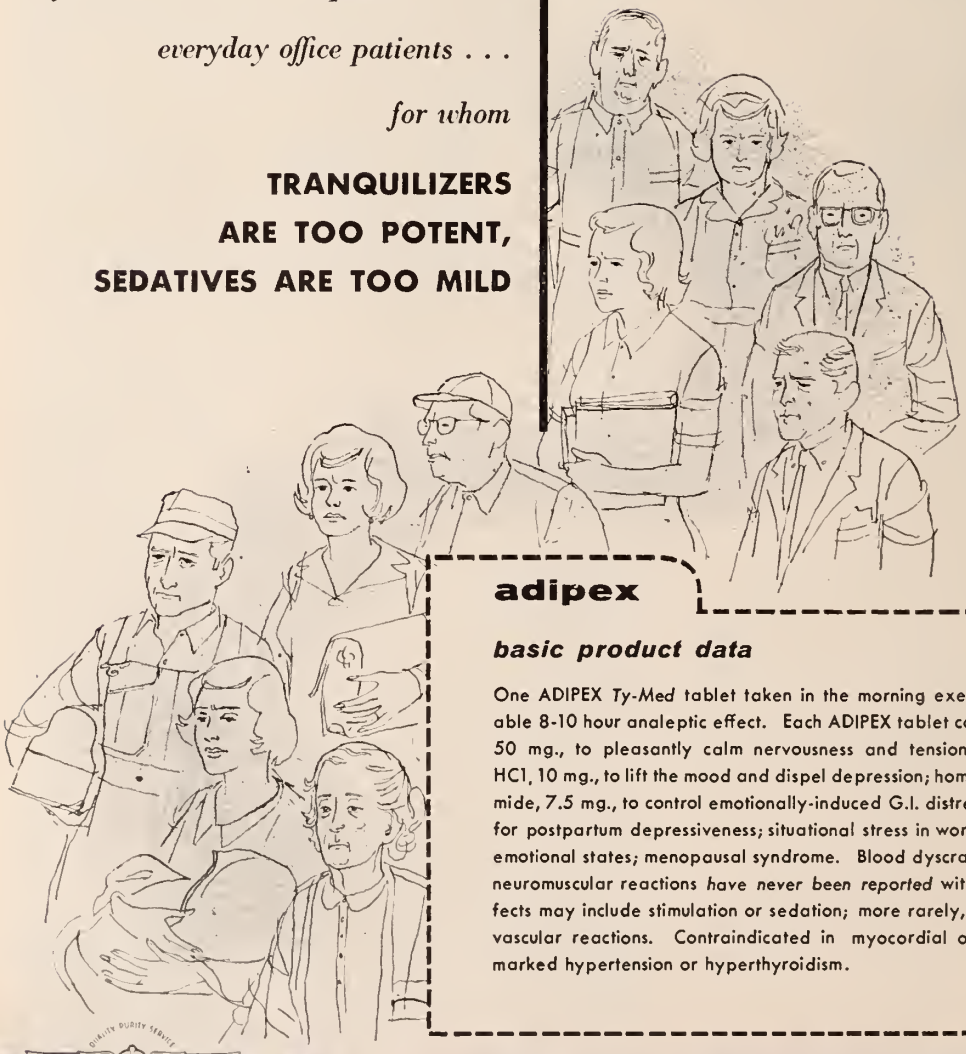
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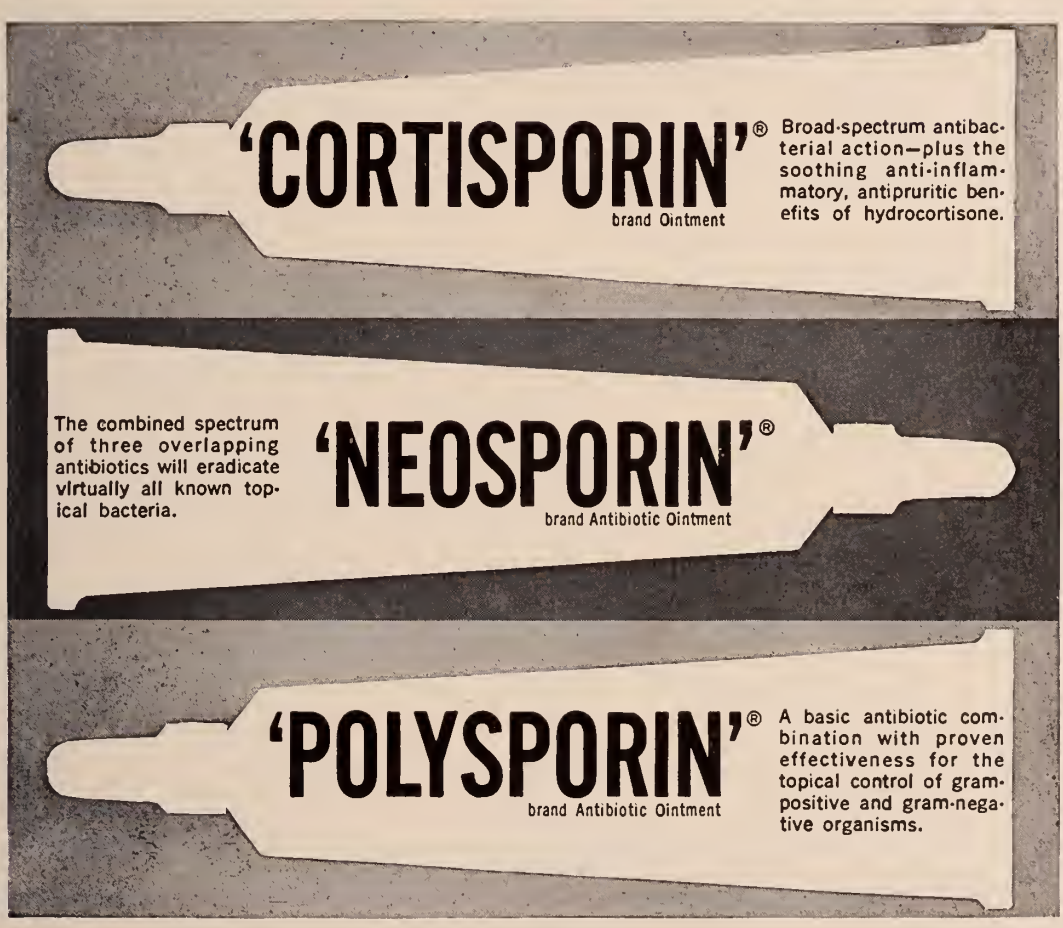
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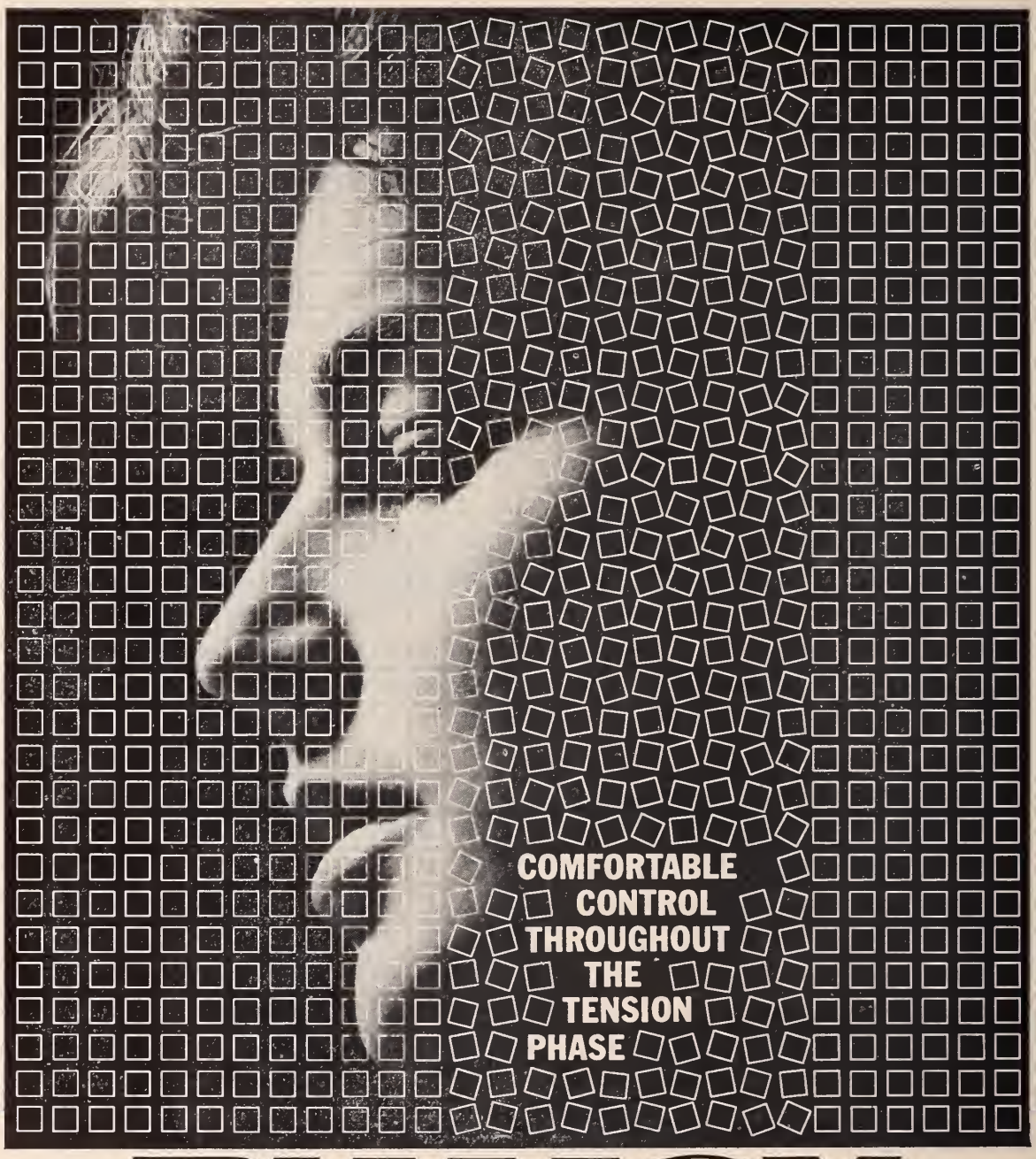
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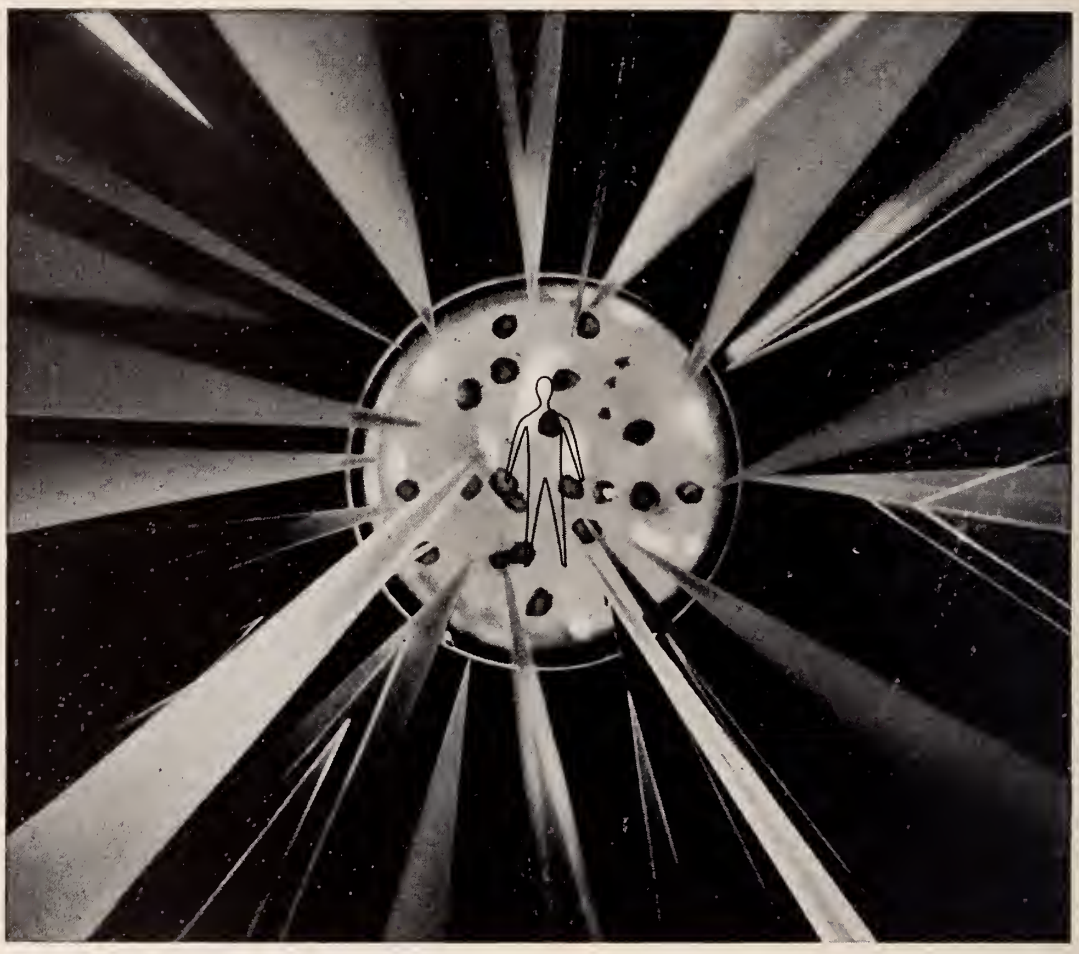
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CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	FO. 8-0070
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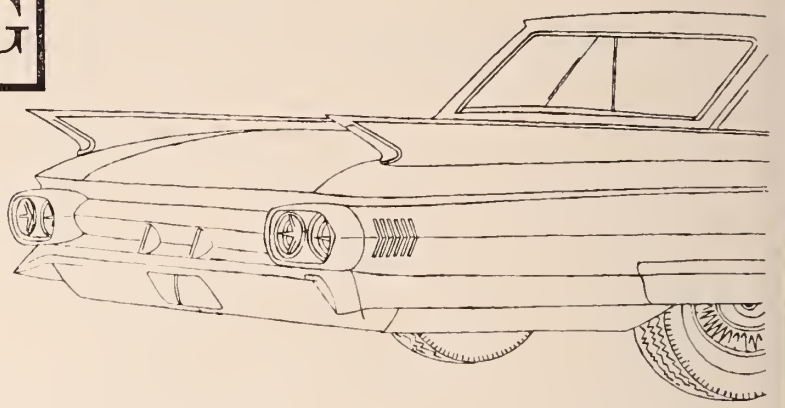
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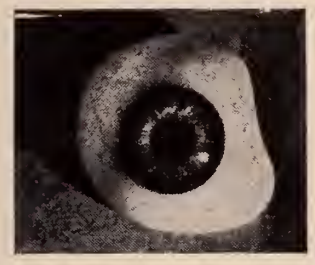
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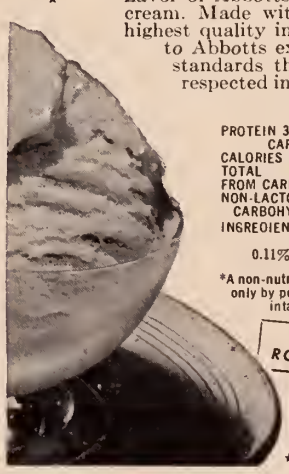
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(1) Carter, S.: *M. Clin. North America* 37:315, 1953.
(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.
(3) Buchthal, F.; Svensmark, O., & Schiller, P. J.: *Arch. Neurol.* 2:624, 1960.

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Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 58, No. 10 — OCTOBER, 1961 — Subscriptions, $3.00 per year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

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Rhode Island Medical Journal,
January, 1961

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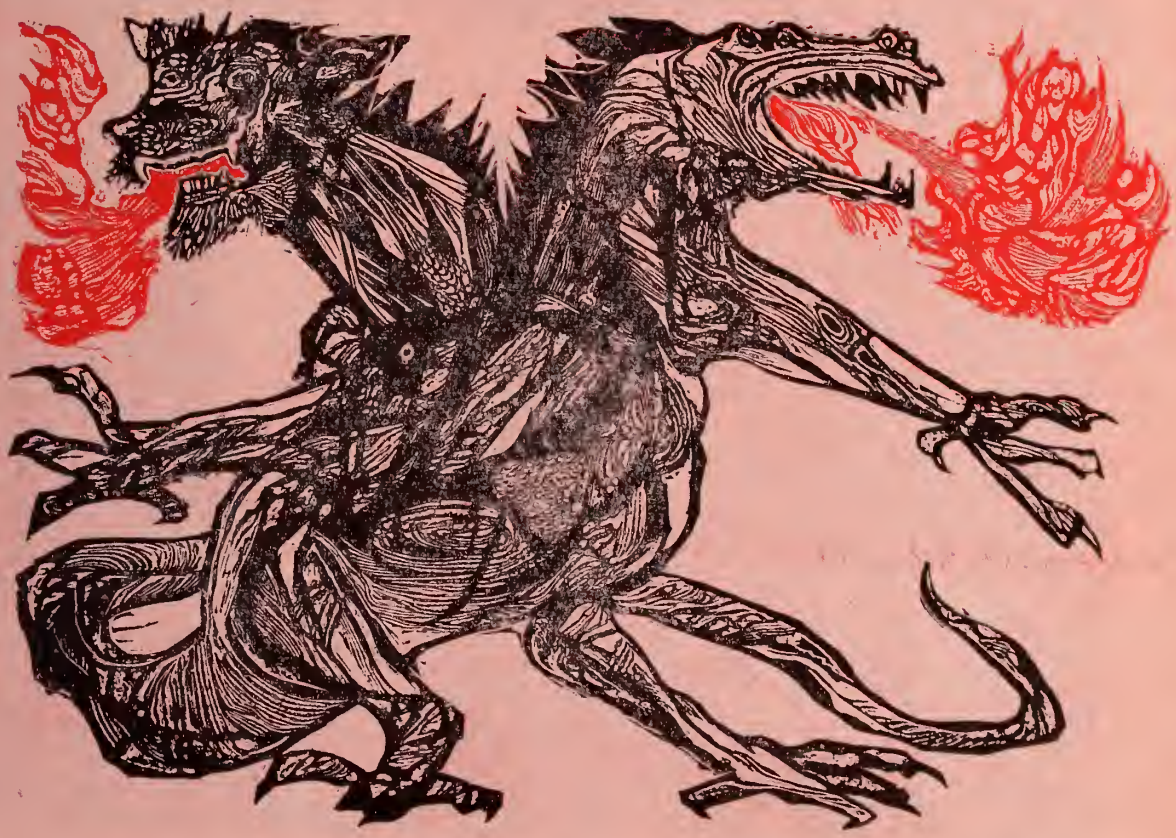
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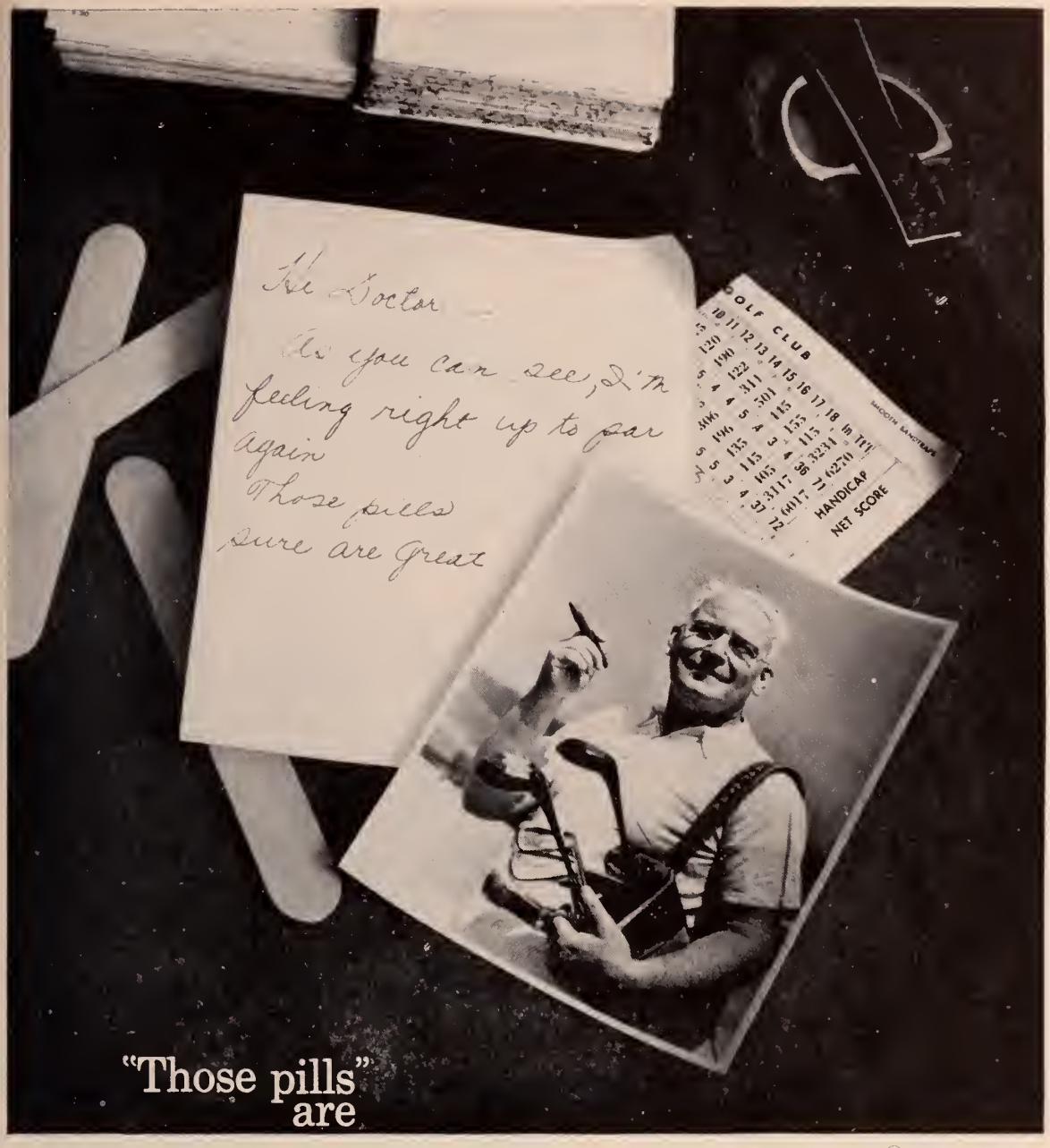
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1. Billow, B. W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S. S.: Southwestern Med. *41*:286, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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When a muscle is strained, it goes into a spasm that produces pain; this is followed by more spasm for splinting, and then more pain.

When you prescribe Trancopal, you break this vicious cycle and relieve the patient's discomfort. Trancopal will ease the spasm and consequently the pain, and its mild tranquilizing effect will make the patient less restless. You can then start him on purposeful exercise or physical therapy.

In addition to its usefulness in syndromes resulting from overstraining (such as low back pain or tennis elbow), Trancopal will relax the spasm and pain that are features of torticollis, bursitis, fibrositis, myositis, ankle sprain, osteoarthritis, rheumatoid arthritis, disc syndrome and postoperative muscle spasm. Trancopal is available in 200 mg. Caplets® (green colored, scored) and in 100 mg. Caplets (peach colored, scored), bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Winthrop LABORATORIES
New York 18, N.Y.

1626M



in bacterial otitis media

Panalba* promptly

to gain precious therapeutic hours

In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.
SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, and a few cases of leukopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.
CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.

*Trademark, Reg. U. S. Pat. Off.

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Panalba
your broad-spectrum antibiotic of first resort.

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1 2 3 4

clinical studies repeat...

ARLIDIN IMPROVES HEARING[1]

ARLIDIN IMPROVES HEARING[2]

ARLIDIN IMPROVES HEARING[3]

ARLIDIN IMPROVES HEARING[4]

1

"significant hearing improvement" occurred with Arlidin in 32 of 75 patients with recent onset hearing impairment due to labyrinthine artery ischemia.

Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

3

Arlidin "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.

Seymour, J. C.: Laryngology & Otology 74:133, 1960.

Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.
See PDR for packaging.

Protected by U.S. Patent Numbers: 2,661,372 and 2,661,373.

2

vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness... "vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:098, 1960.

4

early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin]... energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

impaired hearing
tinnitus
vertigo

when due to ischemia of the inner ear...

arlidin®

brand of nylidrin hydrochloride N.N.D.

Clinical benefit in approximately 50% of cases of recent onset hearing loss treated with adequate vasodilator and other supportive therapy is also reported by Sheehy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

NOTE—before prescribing Arlidin the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects and contraindications, etc. Write for complete detailed literature.

u. s. vitamin & pharmaceutical corp.
Arlington-Funk Laboratories, division
800 Second Ave., New York 17, N.Y.



an added measure of protection for little patients

against relapse
against "problem" pathogens

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

pediatric drops
syrup

● full antibiotic activity ● lower milligram intake per dose ● up to 6 days' activity with 4 days' dosage ● uniformly high, sustained peak activity ■ **syrup** (cherry-flavored), 75 mg./5 cc. tsp., bottles of 2 and 16 fl. oz. Dosage: 3 to 6 mg./lb./day—in four divided doses. **pediatric drops,** 60 mg./cc., 3 mg./drop, 10 cc. bottles with calibrated dropper. Dosage: 1 to 2 drops/lb./day—in four divided doses.

PRECAUTIONS: As with many other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs discontinue medication. Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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after a $500 deductible which may be paid by Hospitalization Insurance, Service Plan or out-of-pocket

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Drugs and medicines prepared from a doctor's prescription.
Laboratory and X-ray services, including X-ray and radium treatment.
Anesthesia, oxygen, blood and blood plasma, and surgical dressings.
Artificial limbs and eyes, casts, splints, trusses, braces and crutches; rental of iron lung.
Local professional ambulance transportation to and from a hospital for inpatient treatment.

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Age of Member	Member Only	Member and Spouse	Member, Spouse and Children	Member and Children
Under 40	**$10.40**	**$ 22.20**	**$ 35.00**	**$ 23.20**
40-49	**18.20**	**38.00**	**50.20**	**30.40**
50-59	**32.40**	**66.00**	**78.20**	**44.60**
60-65*	**52.00**	**103.00**	**109.00**	**58.00**

* During the initial enrollment the age limit for policy issuance is the 70th birthday. Although the age limit for policy issuance after the initial enrollment is the 65th birthday, the policy is renewable to 70 at age 60-65 rates.

***Special extension of coverage policy providing coverage beyond age 70 with a maximum benefit of $5000 for each disablement with a $750 deductible, available upon request at that age without evidence of insurability.**

SOME HIGHLIGHTS:

MENTAL DISORDERS are covered up to full $10,000 maximum, if patient is confined in a non-government hospital.

PREGNANCY beginning after insurance in force is covered.

CONGENITAL DEFECTS are covered, if such expenses are incurred either (a) for a child born to a mother who is already insured, or (b) more than three years after the effective date of the Covered Person's insurance.

COSMETIC SURGERY is covered, if the condition to be treated is a result of injury sustained while the Covered Person is insured.

RECURRENT conditions are covered.

NO SPECIFIC LIMIT on number of days in hospital or for professional nursing expense.

WORLDWIDE COVERAGE.

THE EXCLUSIONS:

The plan does not cover expenses which are not reasonable or necessary or caused by or resulting from: the hazards of warfare; injury or sickness contracted while in the armed forces; suicide or attempt thereat; self-inflicted injury; injury or sickness covered by Workmen's Compensation or Occupational Disease Law; supplies or services which are furnished by or at the expense of the Federal Government or an agency thereof; treatment for alcoholism or narcotic addiction; or cosmetic surgery or congenital defects or air travel, except as specified in the policy.

TERMINATION:

As long as the Society's plan remains in force and you remain a member of the Society and pay the required premium, your insurance cannot terminate prior to age 70*. Similarly, dependent insurance continues concurrently with the member's policy as long as the person remains a Dependent as defined if premium is paid.

Full Details of Coverage Are in Policy

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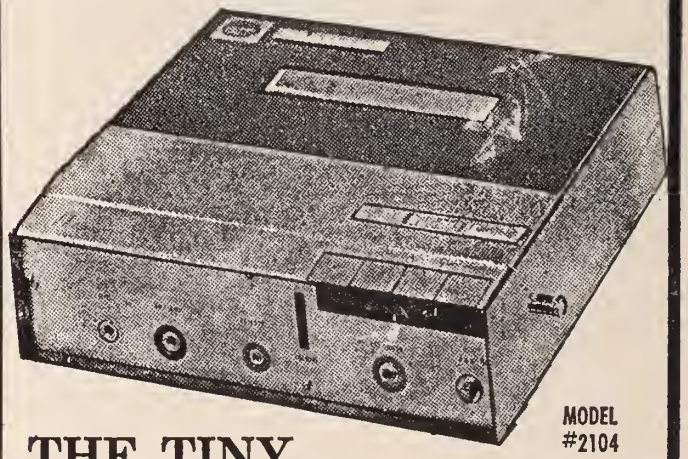
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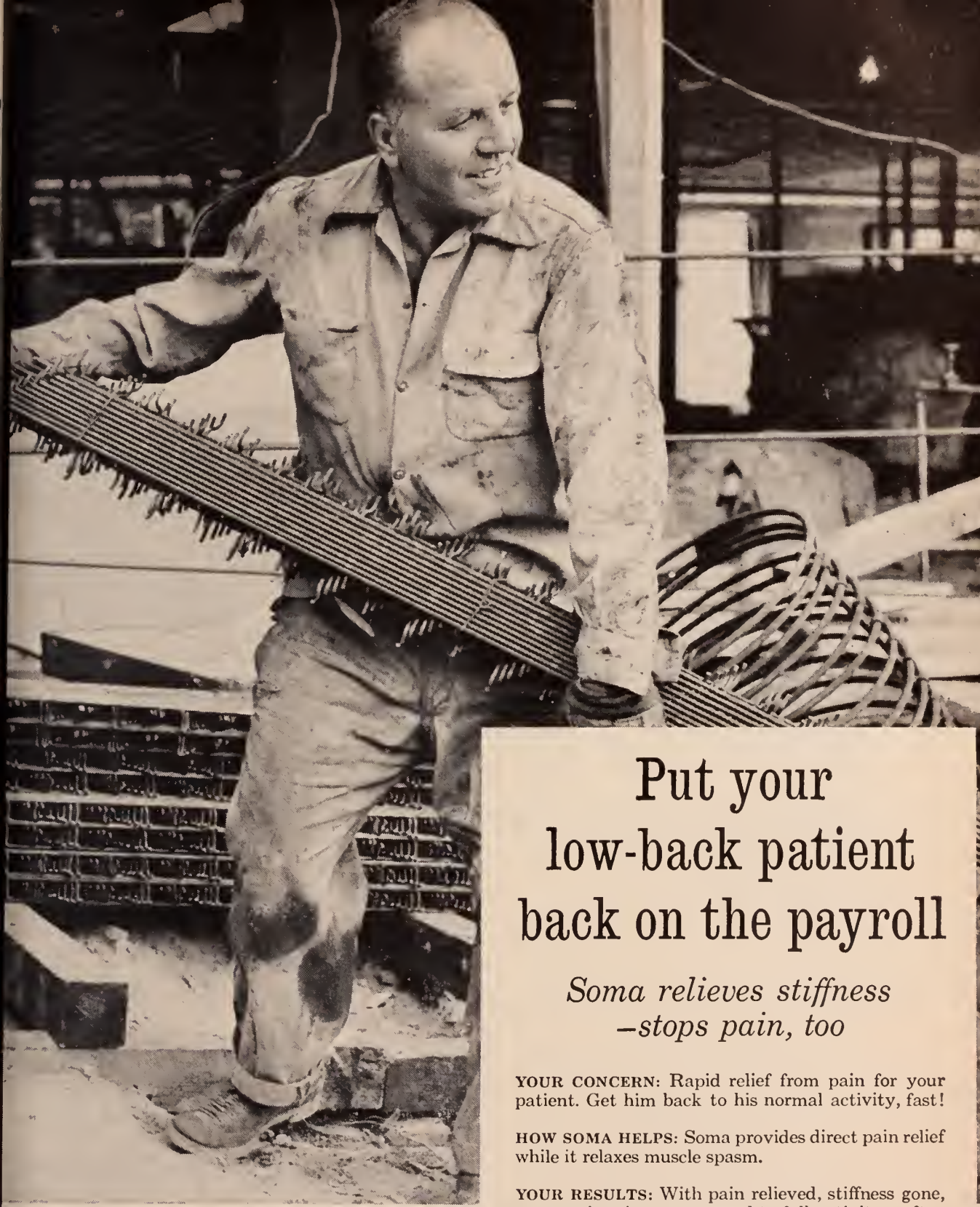
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Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



effective, palatable, economical

CREMOSUXIDINE® [SULFASUXIDINE® SUCCINYLSULFATHIAZOLE SUSPENSION WITH KAOLIN AND PECTIN] reduces fluidity of stools, reduces enteric bacteria, adsorbs toxins, and soothes the irritated intestinal mucosa.

Chocolate-mint flavored...readily accepted by patients of all ages.

Additional information on CREMOSUXIDINE is available to physicians on request.

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CREMOSUXIDINE AND SULFASUXIDINE ARE TRADEMARKS OF MERCK & CO., INC.

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- relieve sneezing, runny nose
- ease aches and pains
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- reduce fever, chills

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Each CORIFORTE Capsule contains

CHLOR-TRIMETON® (brand of chlorpheniramine maleate)	4 mg
salicylamide	0.19 Gm
phenacetin	0.13 Gm
caffeine	30 mg
methamphetamine hydrochloride	1.25 mg
ascorbic acid	50 mg

The cigarette that made the Filter Famous!



It's true. Kent's enormous rise in popularity—with all the attendant magazine and newspaper stories—really put momentum to the trend toward filter cigarettes!

So, Kent is the cigarette that made the filter famous. And, no wonder. Kent's famous Micronite filter is made from a pure, all-vegetable material. A specially designed process at the P. Lorillard factory compresses this material into the filter shape and creates an intricate network of tiny channels which refine smoking flavor.

Kent with the Micronite filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild.

That's why you'll feel better about smoking with the taste of Kent.

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ARMOUR PHARMACEUTICAL COMPANY
ANNOUNCES THE FIRST SELECTIVE TENSITROPIC

L I S T I C A®

I am pleased to inform you of the latest development in our Company's continuing research for superior chemotherapeutic agents.

For patients suffering from tension/anxiety states, we are offering the medical profession Listica— a new and selectively different monocarbamate. Frankly, we would be hesitant about entering a field already crowded with good drugs were it not for the marked differences Listica presents.

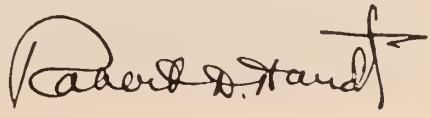
Listica is **not** "just another tranquilizer." We, therefore, call it **The First Selective Tensitropic**. Here are the reasons why:

New Listica allays tension/anxiety in as many as 89% of cases by selectively inhibiting impulses through internuncial pathways of the central nervous system. However, it does not affect the unconditioned response; thus, Listica does not induce apathy or impair acuity.

The past three and one-half years of clinical studies have demonstrated the safety and efficacy of Listica in 1,759 patients. There have been **no reports of contraindications, toxicity, habituation or serious side effects.**

One tablet q.i.d. is adequate dosage to allay tension/anxiety, maintain acuity, and promote **eunoia***—"a normal mental state." This simple, effective dose remains the same, even in maintenance therapy.

We are sending you samples and published clinical reports on Listica. We will be happy to send you a copy of the first "Symposium on Hydroxyphenamate" on request. I believe you will find Listica a valuable addition to the arsenal of chemotherapeutics for combatting tension/anxiety in your practice.



Robert A. Hardt, President

P.S.: Physicians who prefer generic names prescribe "Hydroxyphenamate, Armour."

LISTICA—Hydroxyphenamate, Armour. © 1961, A.P. CO. *Stedman's Medical Dictionary.

ANNOUNCING THE FIRST

Symbols of the Age of Tension/Anxiety



LISTICA by ARMOUR

allays TENSION/ANXIETY...
maintains acuity...promotes eunoia*...
facilitates somatic diagnosis and therapy

SELECTIVE TENSITROPIC

LISTICA®

lifts the facade of TENSION/ANXIETY

New Listica allays tension/anxiety in as many as 89% of cases,[2-13] by selectively inhibiting impulses through internuncial pathways of the central nervous system. Whether the patient's tension/anxiety is psychosomatic or a complication of somatic disorder, Listica reduces or eliminates the excess impulsivity seen in tension/anxiety states.

maintains normal acuity

Unlike many drugs, Listica does not affect unconditioned response or normal motor activity. Thus, Listica allays tension and anxiety without inducing apathy or impairing acuity; patients are able to pursue normal activities, such as driving, reading, writing, etc., without interference from drug therapy.

enhances physician-patient rapport

As it removes tension/anxiety, fear and frustration, LISTICA PROMOTES EUNOIA*—"a normal mental state." It bares the patient's true somatic condition, and facilitates diagnosis and therapy. Patients are more tractable to concomitant drug therapy, respond better, faster.

without known toxicity or contraindications

Listica is safe, as well as effective. Chronic studies[14] in rats (12 months) and dogs (6 months) were free of toxic manifestations at oral dosage levels as high as 200 mg./kg./day (approximately 10 times the recommended human dosage). No macroscopic or microscopic changes in tissues, organs or blood indicative of toxicity were observed, even at doses up to 320 mg./kg. In humans, there have been no adverse blood, urine or cardiac changes; liver profiles were negative, and jaundice has not been noted.

without serious side effects or habituation

During three and one-half years of clinical study in 1,759 patients,[2-13] Listica has produced no serious side effects. Less than 4% of patients experienced any side effects, and these were invariably minor and transient. Most frequent (38 cases) was mild drowsiness, which disappeared after the first few days of Listica therapy. Habituation, cumulative effects, or withdrawal symptoms have not been noted, even in patients taking Listica as long as two years.

with convenient dosage and availability

One Listica tablet, q.i.d., is the recommended dosage. Listica is supplied in bottles of 50 tablets on prescription only, by pharmacies everywhere. Each tablet contains 200 mg. of Hydroxyphenamate, Armour.

References:

[1]Bastian, J. W.: Classification of CNS Drugs by a Mouse Screening Battery. To be published in Intern. Arch. de Pharmacodynamie; [2]Hubata, J. A., and Hecht, R.A.: Review of Clinical Use of Hydroxyphenamate (Listica) in 1,759 Patients. To be published in Clinical Medicine; [3]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [4]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). *Ibid;* [5]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept., 1961; [6]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. *Ibid;* [7]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. *Ibid;* [8]Davis, O. F.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. *Ibid;* [9]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). *Ibid;* [10]Friedman, A. P.: Pharmacological Approach to Treatment of Headache. *Ibid;* [11]Greenspan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. *Ibid;* [12]Lunde, F., Davis, J., and Gouldmann, C.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. *Ibid;* [13]McLaughlin, B. E., Harris, J., and Ryan, F.: Double Blind Study Involving "Listica," Chlordiazepoxide, and "Placebo" as Adjunct to Supportive Psychotherapy in Psychiatric Clinic. *Ibid;* [14]Bastian, J. W.: Pharmacology and Toxicology of Hydroxyphenamate. *Ibid;* [15]Bossinger, C. D.: Chemistry of Hydroxyphenamate. *Ibid.*

ARMOUR PHARMACEUTICAL COMPANY, KANKAKEE, ILLINOIS

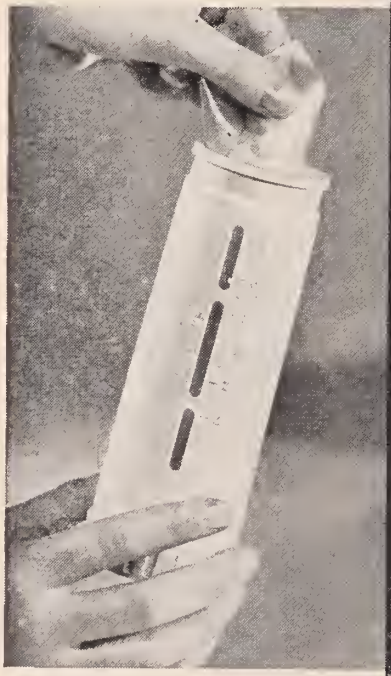
Physicians who prefer generic names prescribe "Hydroxyphenamate, Armour."

LISTICA—Hydroxyphenamate, Armour. © 1961, A.P. CO. *Stedman's Medical Dictionary

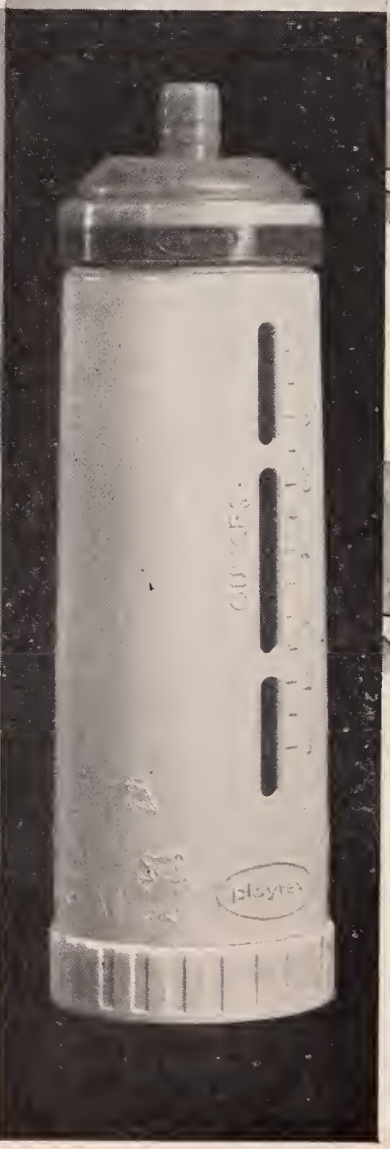
The revolutionary discovery that simulates breast feeding.....



Natural nursing action nipple *induces even sucking that dramatically lessens outside air swallowing and makes baby exercise his jaws. Designed to avert tongue-thrusting and other malocclusions not inhibited by conventional nipples.*

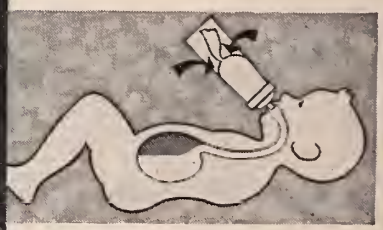


Because the disposable bottle is pre-sterilized, it *eliminates the possibility of contamination through improperly sterilized bottles.*





With conventional bottle *air has to get inside bottle for milk to come out. Nipple often collapses and baby has to suck harder, so more air gets into his stomach. Both overfeeding and underfeeding can ensue, along with the aerophagia and flatulence which can produce colic, spitting up, and after feeding distress.*



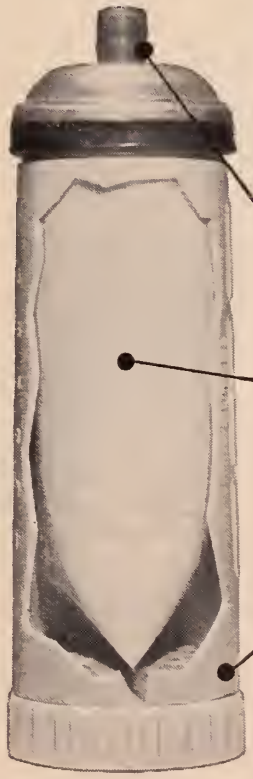
Natural design nipple *of Playtex Nurser assures even flow. Its pliable inner bottle contracts with atmospheric pressure as formula is consumed. Baby takes more nourishing formula, less swallowed air to cause discomforting spitting up and colic.*

dramatically reduces spitting up and colic

To the members of the medical profession who recognize the advantages of breast feeding—here's a completely new concept in baby feeding that all doctors will welcome. The new Playtex Nurser. It features a soft, pre-sterilized inner bottle which is disposable, and a broad, non-collapsing nipple which produces a sucking action similar to that in breast feeding.

Because the outside atmospheric air pressure contracts the soft inner bottle, the formula is withdrawn more naturally than with conventional rigid baby bottles. There is no vacuum formation to set up air blocks. The natural-action nipple induces sucking which makes for less air swallowing, and less spitting up—and in so doing, promotes the healthful mouth-jaw exercises the mother's breast provides.

Colicky infants, problem feeders and premature babies especially will benefit from the breast-like action of the new Playtex Nurser. The fact that the bottle is pre-sterilized and disposable will appeal to mothers who do not breast feed their babies. The fact that the Nurser does so closely simulate breast feeding will be similarly important to the health of any baby fed with it.



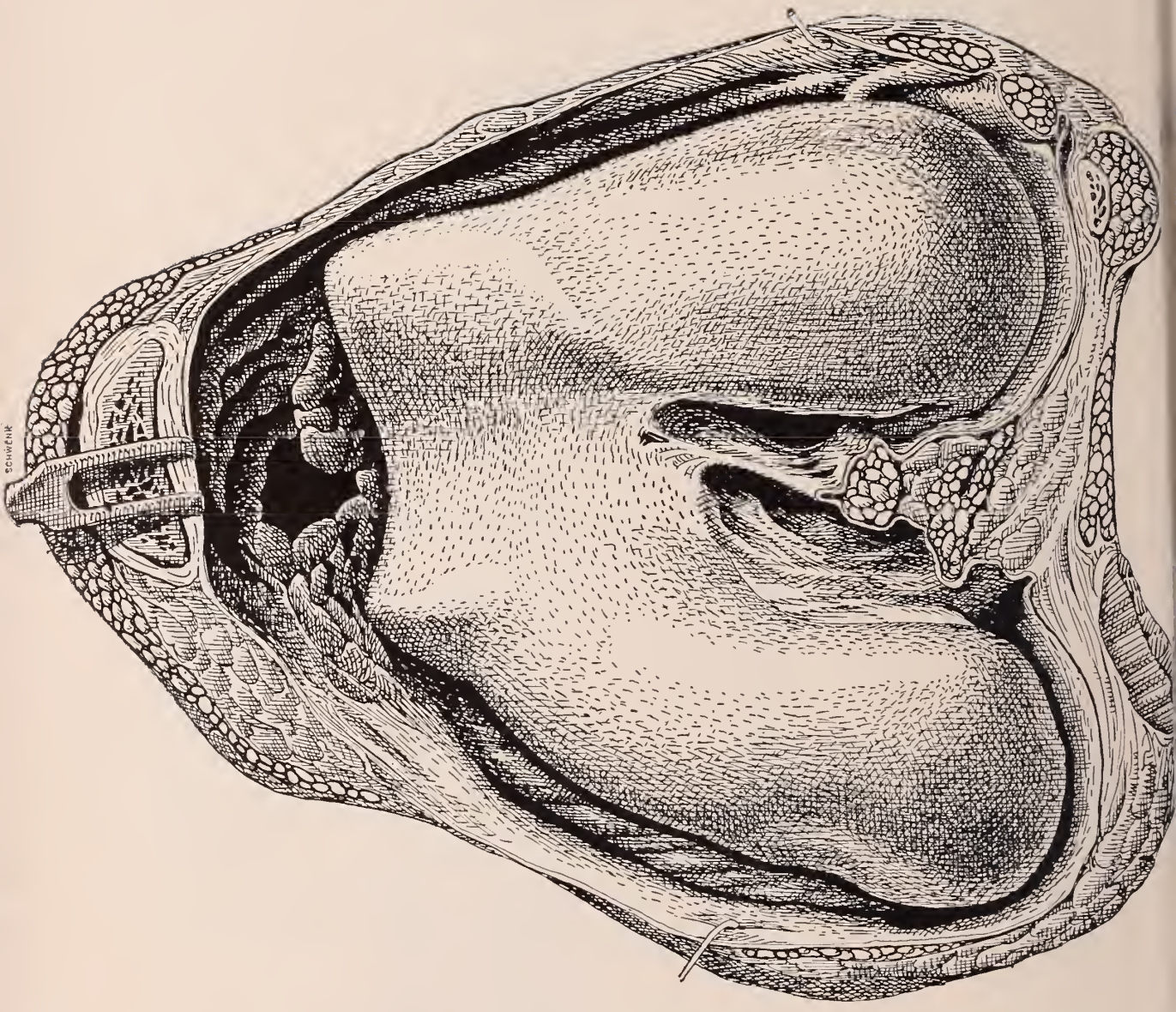
(Cut-out View)

"Nature's Way"

PLAYTEX NURSER

"The nearest approach to breast feeding"

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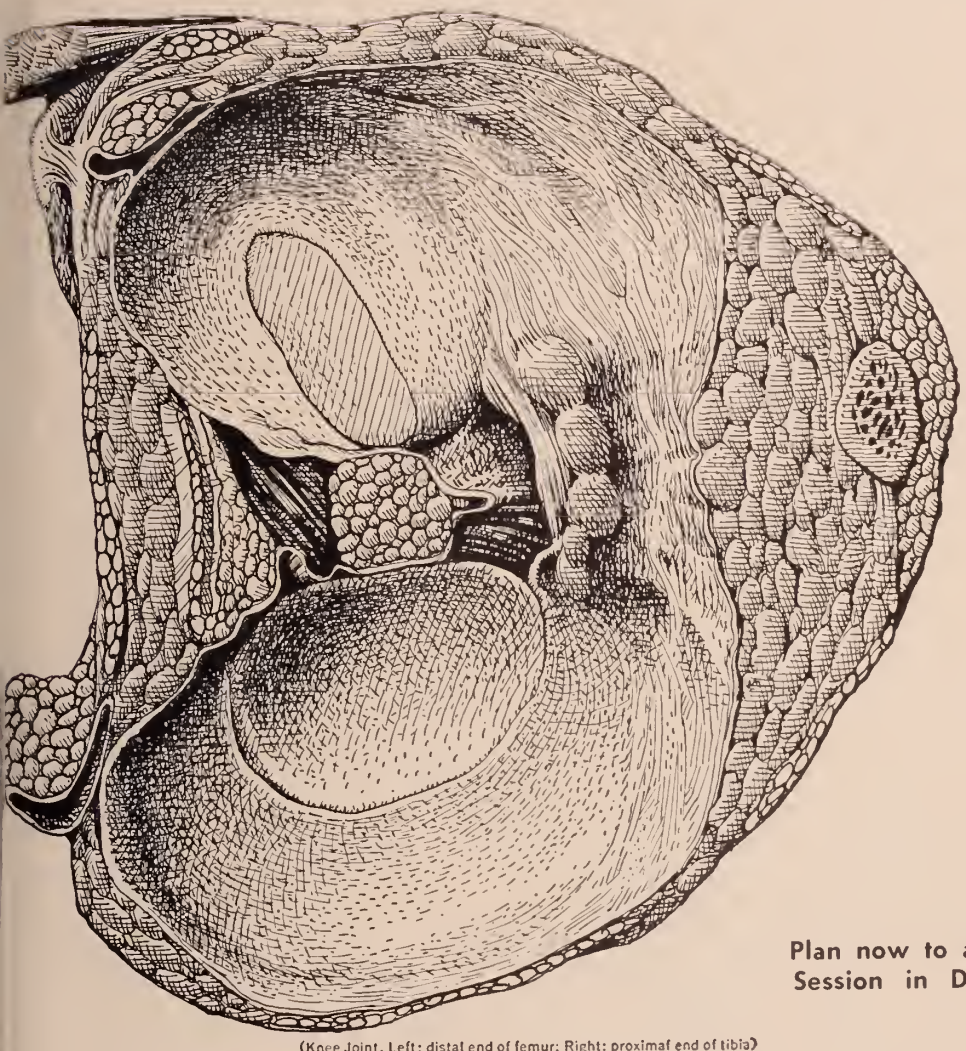
because patients are more than arthritic joints... controlling inflammatory symptoms is frequently not enough!

Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheumatoid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whole patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for the symptom may also be bad for the patient.

Unsurpassed "General Purpose" and "Special Purpose" Corticosteroid...
Outstanding for Short- and Long-term Therapy

Aristocort®

Triamcinolone Lederle



(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

Plan now to attend the A.M.A. Clinical Session in Denver, November 27 - 30

ARISTOCORT is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

Supplied: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle LEDERLE LABORATORIES · A Division of AMERICAN CYANAMID COMPANY · Pearl River, New York

When it's more like "grippe" or



"flu" than a simple cold, but an antibiotic is not indicated... prescribe NEW WIN-CODIN* Tablets

New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

Codeine phosphate 15 mg.—to relieve local and generalized pain and control dry cough

Neo-Synephrine® 10 mg.—to shrink nasal membranes and open sinus ostia

Acetylsalicyclic acid 300 mg. (5 grains)—to reduce fever and relieve aching

Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

Winthrop LABORATORIES
New York 18, N. Y.



Today's little "limey" needs a half barrel of orange juice

...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

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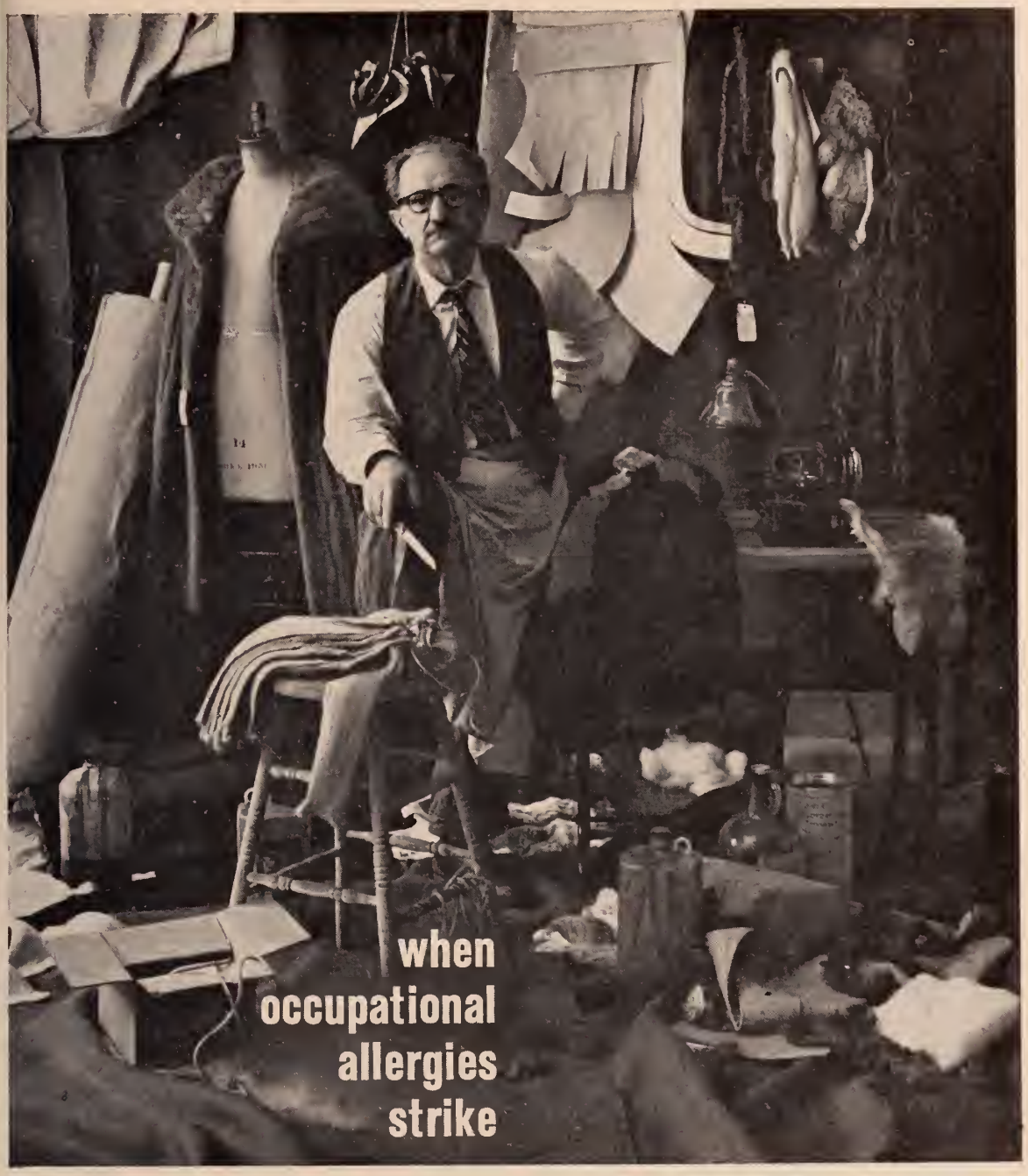
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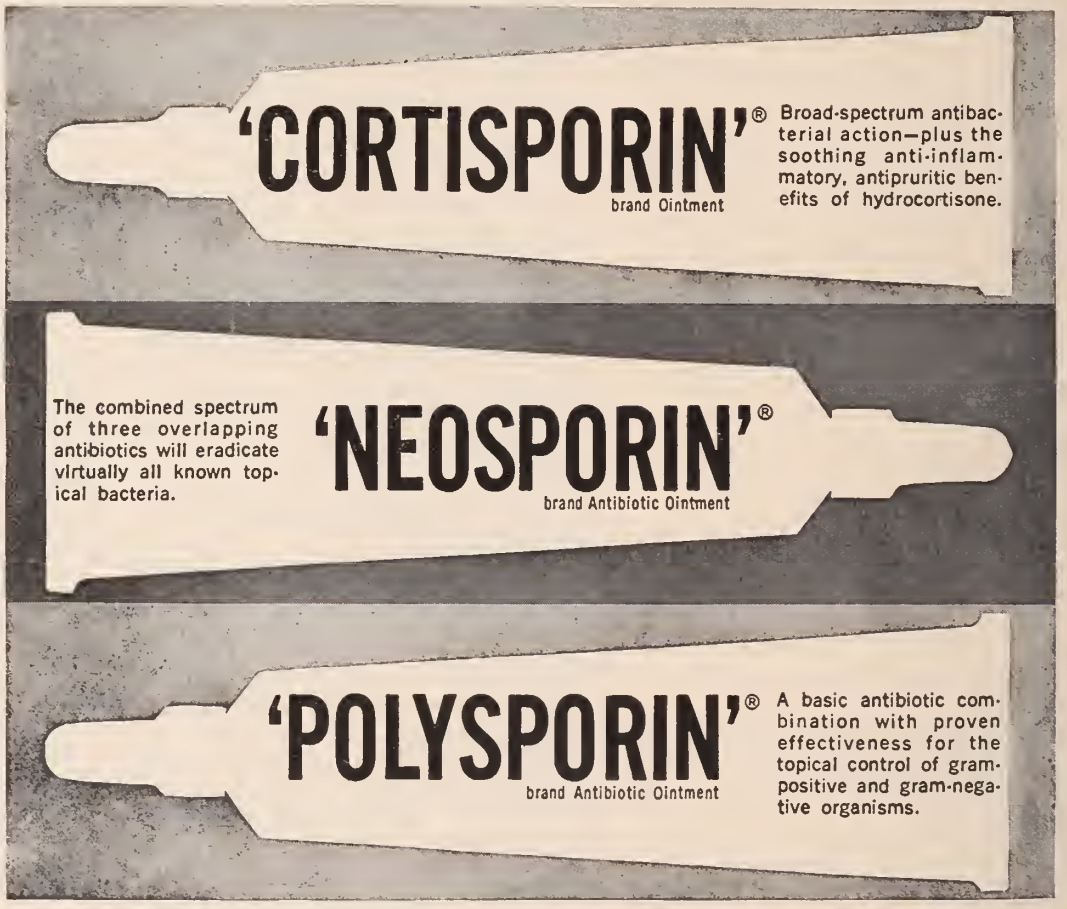
Case history courtesy of Joel Goldman, M.D., Johnstown, Pa.
These photographs of Dr. Goldman's patient were taken on November 10, 1960.
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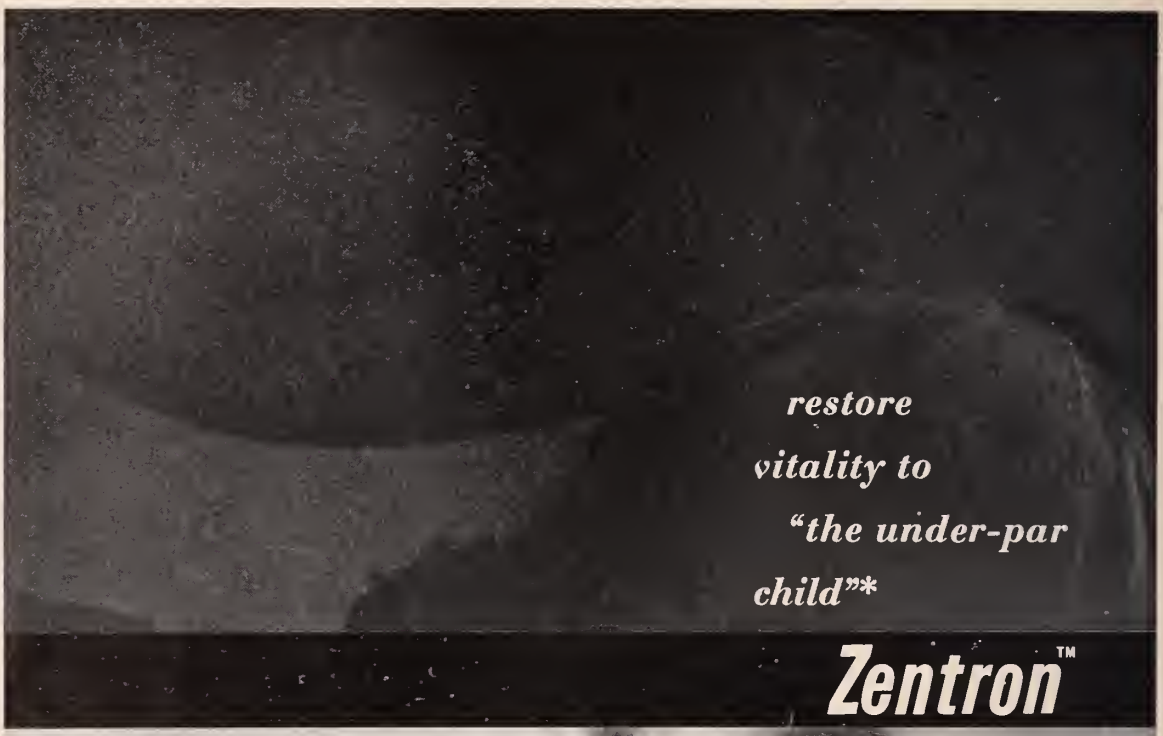
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Editorials • • •

Traffic Laws and Highway Safety

Public opinion could force the adoption of uniform traffic laws throughout the country, thereby saving countless lives, a spokesman for one of the nation's largest automobile insurers said recently.

"The lives that could be saved by such a reform could never be counted, nor could pain and suffering that would be spared untold thousands ever be fully documented," he declared.

A look at the 1960 highway traffic toll indicates that such a program would be based on fact rather than fancy. Violations of traffic laws figured in more than 80 per cent of all personal injury accidents last year. "We know," said the spokesman, "that in some of these cases, confusion and misunderstanding of the law caused the violations."

Signal lights mean different things in various parts of the country. One state stipulates that an amber light is a walk light for pedestrians while in a neighboring state, the amber light merely denotes caution before the red signals are flashed. In one state a motorist stops immediately when the amber light comes on because he knows it is a walk light. If he did the same thing in the next state the car behind would slam into him.

Warning signs differ from state to state, speed limits change radically and road markings vary. In one state it is proper to make a right turn on a red light; in another this constitutes a violation. Reporting procedures vary from town to town and many towns even fail to report non-fatal accidents. The varied interpretation of operating-under-the-influence laws throughout the country make national studies on this complex safety problem nearly impossible.

The need for uniform traffic laws in the nation is only too obvious to the public which must cope with this dangerous state of confusion.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 686

VOL. 58, NO. 10 OCTOBER, 1961 Subscriptions, $3.00 per year
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The Prolongation of Dying

A middle-aged woman complained to the chief of staff that the resident insisted on keeping her mother alive with intravenous fluids. "My mother" said the complainant, "is 89 years old. She had a stroke a week ago and since then has been unconscious, incontinent and is obviously dying. No one pretends that these needles will save her life. Why not pull out the needle and let her die in peace and dignity?" The chief of staff muttered something about "where there's life, there's hope"; but the woman said he didn't believe that himself in this case. The doctor retreated and added "Well—our job is to keep people alive, not to let them die." The woman retorted: "I don't ask you to shoot her. I simply ask you to let her be."

The chief of staff refused to change the orders. The woman threatened to sue the hospital for an assault, as she would not give permission for "the needles."

This highlights a dilemma that is getting increasing attention. There is, it is asserted, a difference between prolonging living and prolonging dying. Here is a quotation from the June 9, 1961, *Medical World News* that touches on the problem:

> Dr. John R. Cavanagh, psychiatrist and lecturer in sacred theology at Catholic University Medical Center, Washington, D. C., directly challenges the use of desperation measures in terminal cases. In a talk before hospital chaplains, the former president of the Guild of Catholic Psychiatrists declared: "There is a point at which the physician not only should refrain from prolonging life, but should actually withdraw 'extraordinary' measures of keeping the patient going.
>
> "It is my conviction that when death is inevitable, when the dying process is beyond doubt, the patient should be allowed to die unencumbered by useless apparatus.
>
> "In the youthful, previously healthy patient, it may be hard to recognize the point at which the illness becomes irreversible. Life-prolonging measures must be used vigorously in such cases. But in the older patient with a fatal illness, the point is not difficult to distinguish.
>
> "When there is no longer any question, then *only natural means* of treatment need be employed," the 56-year old physician believes.
>
> Citing his Church's general stand on preserving life, Dr. Cavanagh notes the distinction between natural, ordinary and extraordinary means. He believes the physician is obliged to use only "normal nursing care, feeding by mouth, giving fluids through spoon feeding, if necessary, and the relief of pain, insomnia and mental anguish." Unlike some theologians, he does not in general include intravenous feeding in this category.
>
> This normal care, however, should not be left to attendants. "Too many patients," he finds, "are being relegated to the hands of interns and nurses. The physician who severs himself from the dying patient misses an important part of therapy. Furthermore, he can provide help and comfort that even a clergyman cannot. Since this may be the family's first experience with death, they need the physician's support and comfort."
>
> The Washington specialist believes that "Dying is easy for the dying.
>
> "When the patient *knows*, the anxiety is overcome." For the living, however, the time is not easy, and futile efforts by the physician to postpone inevitable death may make it harder.
>
> Dr. Cavanagh asks: "Must we never pull out the tubes, take out the needles and remove those instruments which have ceased to have value? Or can't we just put clean sheets on the bed and allow the family to share any remaining hours of consciousness?"
>
> One reason for the continued practice of prolonging the dying process, Dr. Cavanagh believes, is the growing problem of malpractice suits. The influence of "our big metropolitan hospitals" has also been felt. But a deeper reason has been the change in the practice of medicine, with increased specialization and increased reliance on gadgets and machinery. Science has produced so many methods of supporting the dying organism that it becomes "an affront to the physician's sense of power" when a patient dies.

Dr. Cavanagh's thesis is certainly well-intended and well-reasoned. Still, one wonders about this distinction between "natural" and, presumably, "unnatural" means. Thus, giving liquids by spoon is "natural," whereas giving fluid by vein is "unnatural." In a sense, all medicine is unnatural, because it requires an interference with what would otherwise happen to the patient "naturally." If it were not for vaccination, the child might (in a natural way) get small-pox. Were it not for antibiotics and chemotherapy, "nature" would have taken its course and ended many lives that were saved by modern medication.

It may be true that the basic reason for our trying desperate measures is our own anxiety. But it is entirely proper for physicians to have this anxiety. One would not want to live with

the thought that he failed to do something he might have done. We have to assume that every life is worth saving, and that all living is precious. Maybe this isn't so—but since it is the basic underpinning of our ethics and practice, most of us would hate to see this doctrine replaced by one which allows of each of us to decide when to stop trying.

The Tradename as a Spur to Progress

Have you ever heard of the 'Double Happiness' ping-pong ball? 'Far Reaching' wine? 'Heaven Temple' canned fruit? These are a few of the brand-name products that have received accolades from the Chinese Communist government, which has just embarked on a plan to identify quality with trademark names. The *People's Daily* (a Chinese Communist party newspaper) said editorially: "Increased production of branded goods is closely related to the personal interest of the mass of consumers." Thus, the Chinese Communists have learned what we Americans have long known. A well-established tradename is an insignia of quality.

The American use of trademark names is not restricted to the prescription drug industry. The food industry uses such badges of quality as: "Cheerios"; "Crisco"; "Jello"; "Sanka"; and "Spam." A shopper in any supermarket finds scores of trademark names for food products, and prefers it that way. She knows what she wants and what she gets. She can find chemical products sold under trademarks such as "Calgon," "Clorox," or "Drano." She asks for "Band-Aids" or "Q Tips" or "Kleenex." Her husband drives a Falcon or a Corvair. He talks into a "Voice-Writer" or a "Dictaphone" unless his secretary uses a "Stenotype" machine. Maybe he takes pictures with a "Polaroid" Land camera, or with a "Kodak" and refreshes himself with a "Coke."

Trademarks are also proudly used in the textile, synthetics, and plastic industries, where research has developed new products such as those sold under the trademarks, "Dacron," "Orlon," "Styrofoam" and "Saran Wrap."

These trademarked products are either new combinations of matter (as are the new chemicals) or new forms of a standard product, like the "Polaroid" Land camera. A product embodying a new idea is generally given a tradename. After all a man has the right to be rewarded for the superior skill that results in a better product. Trademarks are one way of insuring that right. In the prescription drug industry the wide use of tradenames is a reflection of the wonderful creativeness of that industry, of the medical advances it has produced, of the new medicines that have so greatly reduced disability and prolonged life.

There is a superficial and glib plausibility to the thesis that drug companies should use generic names, and indicate their brand simply by the name of the company. But—let's face it—one of the incentives to progress is the hope of a reward either in terms of bigger sales or in terms of the prestige that goes with a proudly displayed tradename. This balance of rewards has led to the development of the fabulous American drug industry. There is a lot of mischief potential in the idea of upsetting this balance and inviting inferior and substandard manufacturers to reap the benefits of the drug research conducted by the more progressive companies. Destruction of tradenames would be taking out the "sterling" mark, erasing the "guild" symbol, and bleaching out one of the characteristic features of American industrial productivity.

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An Implantable Cardiac Pacemaker for Complete Heart Block*

Automation proceeds apace. While we do not have electrically wired robots, we do have electrically wired human beings. Here is the report of the successful treatment of complete atrioventricular block by implanting a transistorized mercury-cell pacemaker.

UNTIL recent years, patients with complete heart block (with or without Adams-Stokes episodes) could be treated only by medication with drugs which increase the rate and efficiency of the ventricular contractions. Our medical armamentarium has been increased by the availability of chlorothiazide, molar lactate, and adrenal steroids. Despite these agents, many patients continue to have syncopal attacks and the mortality rate remains high.

With the introduction of electrical devices for driving the heart and stopping ventricular fibrillation, we now have new procedures for the control of the abnormalities of behavior of the heart with complete A-V block. Further refinement of control of the heart rate was achieved through implantation of electrodes into the myocardium of the left ventricle, or against the endocardium of the right ventricle *via* a cardiac catheter.

When it became clear that such electrical devices could control the episodes of ventricular standstill and fibrillation (as well as artificially maintaining a satisfactory heart rate) it became feasible to develop smaller electrical units so that the patient would not be permanently fixed to an electric wall outlet.

At present, such patients may be treated in one of several ways. One is the insertion of a unipolar [1] or dipolar electrode [2] into the cavity of the right ventricle, through a catheter emerging from a vein in the neck. The power source is a small, portable unit that can be carried with the patient. This has the advantages of permitting adjustment of the power supply and heart rate and free replacement of the electrical apparatus. However, there is danger of infection and thrombosis at the catheter insertion site; the inconvenience to the patient of carrying a portable apparatus; the need for permanent anticoagulants, and the possibility of damage to the endocardium of the right ventricle.

The second method is the direct implantation of electrodes into the left ventricular muscle.[3,4] The power source then is a mercury

*Displayed in an exhibit at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 14-17, 1961.

1. Furman, S. and Schwedel, J. B.: New England Jour. Med., 261:943 (1959).

2. Kossman, C. E. and Claps, W.: Personal communication to the authors.

3. Zoll, P. M. and Linenthal, A. J.: *Circulation*, 22:341 (1960).

cell transistorized unit that may be buried in the fat of the abdominal or chest wall, thus making the apparatus entirely internal. This makes the patient independent of an external appliance, and free from the need of anticoagulants. Conversely, it is impossible to vary the heart rate once it has been set. Moreover, the power supply cannot be varied as dictated by the needs of the heart. The pacemaker unit must be changed in 5 years, thus requiring a second, though less major, operative procedure.

SELECTION OF PATIENTS

It is, perhaps, too early to discuss the selection of patients for implantation of a pacemaker. Such a decision, as always, must rest upon knowledge of the natural course of arteriosclerotic heart disease with complete A-V block. Rowe and White[5] recently reviewed 105 patients with Adams-Stokes syndrome and followed them to their deaths. Twenty-three died within two months of the onset of symptoms; and another 19 within two years. Many died suddenly or in recurrent syncopal episodes. Oddly enough, the prognosis for survival was somewhat *less* in those 187 patients with A-V block *without* Adams-Stokes episodes. The average length of survival in both groups together was slightly more than four years.

Thus, the outlook for survival is such that one may feel justified in efforts to treat these patients with artificial devices, provided that the technics are effective and that the mortality rate for the surgical procedure is small. Since the earliest implantations have been done only within the past year, one cannot advise this surgery unreservedly. However, in 14 cases reported by Frank and Zoll,[6] there have been no deaths. Indeed, all their patients are doing well.

We felt justified, therefore, in inserting a pacemaker in the patient described below. We elected the unit developed by Dr. Zoll and the Electrodyne Company (of Norwood, Massachusetts). We decided that the advantages offered outweighed those of the catheter method. This procedure was done by a team of physicians of the Newark Beth Israel Hospital Hemodynamics Department.

This was the third Newark Beth Israel Hospital admission of a 58-year old diabetic, who complained of six to eight fainting attacks a day. He was first admitted in 1959 with a cerebral vascular accident and maintained thereafter on anticoagulants. In November 1960 he developed angina and congestive heart failure.

He was then admitted to the Beth Israel for the second time. A complete heart block was found. Pulse rate was 36; blood pressure 182/66. However, his symptoms were those of primary congestive failure, without evidence of Adams-Stokes syndrome. Workup was not conclusive of a recent myocardial infarct although this was the most likely diagnosis. He was treated with digitalis, diuretics and low salt diet. He improved satisfactorily.

Soon thereafter he showed classical episodes of Adams-Stokes syndrome with syncope and periods of unconsciousness. He was treated with atropine, chlorothiazide, isoproterenol, ephedrine, and finally, prednisolone. After seven weeks of care in the hospital he was discharged without return of his Adams-Stokes syndrome.

A week before his most recent admission on January 16, 1961 he had another episode of syncope. The day before admission he had seven episodes and was then admitted for further care and investigation.

He was a thin male showing signs of a previous left hemiparesis. Pulse was 42 and blood pressure 140/60. There was moderate pallor. Head and neck were within normal limits. The chest was clear. Heart was enlarged. Point of maximum impulse was in the sixth intercostal space in the anterior axillary line. The rhythm was slow with frequent premature beats. There was a grade three systolic murmur over the entire precordium. A2 equal to P2. There was no enlargement of the liver or spleen.

Leucocytes numbered 6,700 with a normal differential count. Red count was 4.2 million; hemoglobin was 13.5 Grams. The urine revealed 10 milligrams per cent of albumin; 2-plus glucose and 1-plus acetone. There were 10 to 15 white cells in sediment, and one to two red cells. Blood sugar was 279; BUN 27; chlorides 103 mEq; potassium 4.14 mEq; and carbon dioxide 38 volumes per cent; SGOT was 15 as was SGPT. An electrocardiogram showed complete heart block with right bundle branch block and occasional ventricu-

4. Chardack, W. M., Gage, A. A. and Greatbarch, W.: *Surgery*, 48:683 (1960).

5. Rowe, J. C. and White, P. D.: Annals of Internal Medicine, 42:260 (1958).

6. Frank, H. A. and Zoll, P. M.: Personal communication to the authors.

lar premature contractions. Ventricular rate was 32, and atrial rate 120 (Figure 1).

Course: The patient was maintained in an oxygen tent and treated with isoproterenol, steroids, ephedrine, chlorothiazide and digitalis. Despite this he had numerous Adams-Stokes attacks—sometimes as many as 12 in a 24-hour period. After two weeks of observation, it was determined that the patient could not be weaned from the pacemaker. For this reason it was elected to perform an implantation of a cardiac pacemaker.

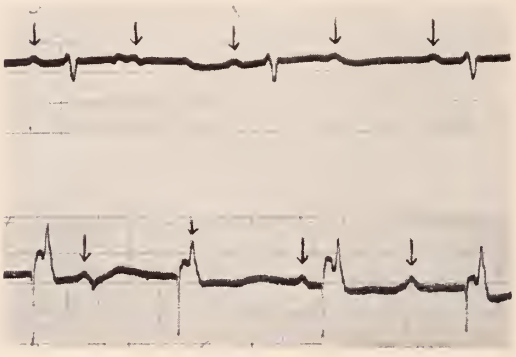


Figure 1. Pre- and postoperative electrocardiograms. Note the independent P waves in both tracings.



Figure 2. Picture of the patient 10 days postoperative. Note the position of the pacemaker box beneath the left clavicle.

On January 27, 1961 a transistorized pacemaker wrapped in Marlex mesh was implanted. The operation was without incident. The pacemaker had been previously set at a rate of approximately 60 per minute. The patient's heart for the ten days prior to surgery had been about 32 per minute. The pacemaker box was buried beneath the pectoralis major muscle (Figures 2 and 3). The electrode wires were led from it through the second interspace into the pericardial cavity and implanted about 15 millimeters apart in the apex of the lateral wall of the left ventricle.

His postoperative course was uneventful. Pulse rate remained a steady 62. The electrocardiogram revealed the continued atrial contractions of between 100 and 120 per minute and the independent ventricular contractions of 60 to 62 per minute with the small electrical "blip" of the pacemaker easily visible just preceding the R wave (Figure 1). The thoracotomy tube was removed on the third postoperative day. He suffered from intermittent diarrhea for 4 days which was controlled with paregoric. He had a mild phlebitis in his right arm at the site of an intravenous injection. He also developed a mild urinary tract in-



Figure 3. X-ray film of the patient 10 days postoperative showing the position of the battery box beneath the clavicle.

fection which was treated with antibiotic therapy. At no time was there any reaction about the implanted pacemaker battery box. He had no further attacks of syncope. The patient was out of bed walking for the first time on the fourth postoperative day.

On the day of discharge an interesting complication was noted. He complained of a throbbing in the abdomen which did not interfere with his sleep but did bother him in certain positions. Examination revealed spasms of the left hemidiaphragm synchronous with the impulse of the pacemaker and the ventricular contractions. It was assumed

that the tips of the wires as they emerged from the left ventricle were touching the left phrenic nerve or for some reason conducting to the left phrenic nerve. Since the patient was not troubled by this complaint, he was discharged. The diaphragmatic contractions ceased spontaneously four days later.

The most recent followup was on April 29, 1961, two months after discharge. He has returned to his regular work as a file clerk and was assuming a second job as a librarian. He was without complaints except for mild fatigability and persistence of angina on two blocks of walking.

The treatment of this patient with complete A-V block by implantation of a cardiac pacemaker has been successful so far. The patient has no discomfort from the implanted battery box, and can enjoy life within the limits of his other diseases.

According to the manufacturer of the pacemaker the battery should last 5 to 6 years, at which time a new unit must be inserted. This will require replacement of the subcutaneous pacemaker only, not the electrodes.

SUMMARY

THE treatment of complete A-V block with an implantable cardiac pacemaker is an effective therapy. A successful case has been reported.

ADDENDUM

Since submission of this report, five more patients have had successful implantations of transistorized pacemakers by members of the hospital team. Four of the patients had preliminary insertion of a dipolar intra-cardiac electrode to sustain life until the implantable unit was obtainable. This was done by Dr. I. R. Zucker, head of the hospital catheterization team. The patient reported herein is well, eight months after insertion of the pacemaker, although a slight slowing of the pulse rate indicates that he may require replacement of the battery unit earlier than anticipated.

The authors are indebted to Dr. Howard A. Frank and Dr. Paul M. Zoll, both of the Boston Beth Israel Hospital. These two authorities graciously, generously and effectively guided our team and supported our efforts.

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The Van Meter Prize Award

The American Thyroid Association again offers the Van Meter Prize Award of $500 for the best manuscript of original and unpublished work concerning "Goiter—especially its basic cause." The studies may relate to any aspect of the thyroid in all of its functions in health and disease. The Award will be made at the Annual Meeting of the Association in New Orleans in May, 1962.

The competing essays may cover either clinical or research investigations, should not exceed 3000 words in length and must be in English. Duplicate, typewritten copies, double spaced, should be sent to Dr. Theodore Winship, 430 N. Michigan Avenue, Chicago 11, Illinois, not later than January 1st, 1962.

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S. Anna Rudovick, M.A.
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The Tuberculosis Problem in Union County

Significance of the Socio-Economic Factors and Suggestions for Managing the Problem

Tuberculosis has long been known as a "crowd" disease. Here Dr. Biber and Miss Rudovick suggest a simple, but practical "field plan" aimed at reducing this controllable disease.

The John E. Runnells Hospital for Chest Diseases is the tuberculosis sanatorium for Union County. This hospital admitted 143 patients for tuberculosis in 1960. Table 1 shows the number of admissions from each municipality in Union County. Elizabeth, the largest city in the county, has a population of 108,000, which is 21 per cent of the county population. This city was the source of 34 per cent of the admissions to the Runnells Hospital. Indeed, 68 per cent of the 1960 admissions came from the three cities: Elizabeth, Linden and Plainfield. Together these make up 38 per cent of the population of the county.

Of the 137 adult admissions, 56 were re-admissions: a rather high relapse rate.

Table 2 shows the earnings of the patients admitted for treatment. Omitting children, homemakers and retired persons, there remain 96 adults who would normally be working. Twenty-five per cent of these were unemployed at the time of admission and 44 per cent made $60 or less per week.

Table 3 gives a breakdown by town of the patients admitted with a diagnosis of tuberculosis who had, in addition, the complication of alcoholism. Of the 93 males admitted, 28 (which is 32 per cent) were alcoholics. Four of the 44 females were alcoholics. Of the 32 admitted with a diagnosis of tuberculosis and alcoholism, 23 were classified as unemployed and 22 of the group were re-admissions.

Table 4 lists 5 suburban towns which together contributed 4 per cent of the 1960 tuberculosis admissions. These towns make up 11 per cent of the county's population. Also listed are the 3 industrial cities (Elizabeth, Plainfield and Linden) whose populations total 193,000 or 38 per cent of the county population. The tuberculosis admissions to the Runnells Hospital from these cities totaled 68 per cent.

Of interest also is the comparison in Table 5 of the admissions with a diagnosis of tuberculosis plus alcoholism for the 5 selected suburban towns and 3 selected industrial cities. *There were no admissions in this category from the suburban towns.* Twenty-three (or 72 per cent) of the 32 patients with a diagnosis of tuberculosis and alcoholism came from the three selected industrial cities.

The data appear to indicate that there are two distinct tuberculosis populations in Union County. One group consists of individuals who

TABLE 1.

1960 ADMISSIONS TO THE RUNNELLS HOSPITAL WITH DIAGNOSIS OF TUBERCULOSIS

Municipality	1960 Census	Total Admissions	New	Re-Admissions	Children*
TOTALS	504,255	143	81	56	6
Berkeley Heights	8,721	2	1	1	0
Clark Township	12,195	1	0	1	0
Cranford	26,424	3	2	1	0
Elizabeth	107,698	63	35	27	1
Fanwood	7,963	1	1	0	0
Garwood	5,426	2	2	0	0
Hillside	22,304	3	2	1	0
Kenilworth	8,379	0	0	0	0
Linden	39,931	11	5	6	0
Mountainside	6,325	0	0	0	0
New Providence	10,243	1	1	0	0
Plainfield	45,330	24	11	10	3
Rahway	27,699	2	2	0	0
Roselle	21,032	9	5	2	2
Roselle Park	12,546	1	1	0	0
Scotch Plains	18,491	4	4	0	0
Springfield	14,467	2	1	1	0
Summit	23,677	2	2	0	0
Union	51,499	5	2	3	0
Westfield	31,447	4	4	0	0
Winfield Park	2,458	2	2	0	0
Out of County	———	1	1	0	0

*All new

TABLE 2.

WEEKLY EARNINGS OF PATIENTS WITH TUBERCULOSIS ADMITTED IN 1960

		Unemp.	Under $40	$40 to $59	$60 to $89	$90 to $109	$110 to $125	Over $125	Others†
2	Berkeley H'ts	0	0	0	1	0	0	1	0
1	Clark	0	0	0	0	0	0	0	1
3	Cranford	0	0	0	0	0	2	0	1
63	Elizabeth	11	6	7	11	8	1	2	17
1	Fanwood	0	0	0	0	0	0	0	1
2	Garwood	0	0	0	1	0	0	0	1
3	Hillside	1	0	0	0	1	0	0	1
11	Linden	4	0	2	1	0	1	0	3
1	New Providence	0	0	0	1	0	0	0	0
24	Plainfield	3	0	0	7	2	1	0	11
2	Rahway	0	0	0	0	0	0	2	0
9	Roselle	2	0	0	2	2	0	0	3
1	Roselle Pk.	0	0	1	0	0	0	0	0
4	Scotch Plains	2	0	0	1	0	0	1	0
2	Springfield	0	0	0	1	0	0	0	1
2	Summit	0	0	1	0	1	0	0	0
5	Union	0	0	0	0	0	0	0	5
4	Westfield	0	1	0	0	0	0	1	2
2	Winfield Pk.	0	0	0	1	1	0	0	0
1	Out of County	1	0	0	0	0	0	0	0
—		—	—	—	—	—	—	—	—
143	Grand Total	24	7	11	27	15	5	7	47

†This column includes 25 housewives, 14 retired adults, 4 school children and 4 preschool children for a total of 47.

TABLE 3.

1960 ADMISSIONS TO THE RUNNELLS HOSPITAL WITH DIAGNOSIS OF TUBERCULOSIS AND ALCOHOLISM‡

Municipality	TOTALS			FIRST ADMISSIONS				RE-ADMISSIONS			
				Employed		Unemployed		Employed		Unemployed	
	Total	Male	Female	M	F	M	F	M	F	M	F
TOTALS	32	28	4	4	0	6	0	4	1	14	3
Elizabeth	18	15	3	2	0	3	0	3	1	7	2
Hillside	1	1	0	0	0	1	0	0	0	0	0
Linden	3	3	0	0	0	0	0	0	0	3	0
Plainfield	2	2	0	0	0	0	0	1	0	1	0
Roselle	4	3	1	0	0	0	0	0	0	3	1
Summit	1	1	0	1	0	0	0	0	0	0	0
Westfield	1	1	0	1	0	0	0	0	0	0	0
Winfield Park	1	1	0	0	0	1	0	0	0	0	0
Out of County	1	1	0	0	0	1	0	0	0	0	0

‡In this combined category (alcoholism plus tuberculosis) there were no admissions at all from Berkeley Heights, Clark, Cranford, Fanwood, Garwood, New Providence, Rahway, Roselle Park, Scotch Plains, Springfield, or Union.

TABLE 4.

1960 TUBERCULOSIS CASES AND HOSPITAL ADMISSIONS OF FIVE SELECTED SUBURBAN TOWNS WITH THREE SELECTED INDUSTRIAL CITIES

Municipality	1960 Census	Reported New Cases	Hospitalized Other Hosp.	Hospitalized J. E. Runnells		Total Hospitalized
				New	Re-Adm.	
FIVE SELECTED SUBURBAN TOWNS						
TOTALS	47,719	9	0	4	2	6
Berkeley Heights	8,721	1	0	1	1	2
Fanwood	7,963	1	0	1	0	1
Mountainside	6,325	0	0	0	0	0
New Providence	10,243	4	0	1	0	1
Springfield	14,467	3	0	1	1	2
THREE SELECTED INDUSTRIAL TOWNS						
TOTALS	192,959	108	14	56	42	112
Elizabeth	107,698	70	5	36	27	68
Plainfield	45,330	24	5	15	9	29
Linden	39,931	14	4	5	6	15

live largely in congested areas of the city and are in poor economic circumstances. The low incidence population consists of individuals who are "better off" economically, have better housing and live in the suburban areas or in the "better" neighborhoods of the cities. They come from areas where the incidence of active tuberculosis is now down to the point where it may be considered sporadic. The patients admitted to the county hospital come largely from the high incidence, low income group. Most of the individuals from the suburbs and from the better neighborhoods of the cities are treated by their own physicians.

WHAT TO DO?

IN THE cities a large number of new cases of tuberculosis develop within a small area. It would seem to us that the tuberculosis problem in this population can best be handled

TABLE 5

1960 ADMISSIONS OF PATIENTS HAVING DIAGNOSIS OF TUBERCULOSIS AND ALCOHOLISM FOR THE FIVE SELECTED SUBURBAN TOWNS AND THREE SELECTED INDUSTRIAL CITIES OF UNION COUNTY, NEW JERSEY

	TOTALS			FIRST ADMISSIONS				RE-ADMISSIONS			
				Employed		Unemployed		Employed		Unemployed	
	Total	Male	Female	M	F	M	F	M	F	M	F
TOTALS	23	20	3	2	0	3	0	4	1	11	2
Elizabeth	18	15	3	2	0	3	0	3	1	7	2
Plainfield	2	2	0	0	0	0	0	1	0	1	0
Linden	3	3	0	0	0	0	0	0	0	3	0

FIVE SELECTED SUBURBAN TOWNS

Berkeley Heights—none
Fanwood—none
Mountainside—none
New Providence—none
Springfield—none

from within these areas. By "from within these areas" we mean the physical presence of tuberculosis field workers within these areas.

A "neighboorhood headquarters" method could be effective in handling this group. The tuberculosis headquarters should be located within the neighborhood involved. This headquarters should have a simple layout. Perhaps a vacant store on the ground level, which would be readily accessible, could be fixed up in a clean and attractive manner. It would be simple to shift such a headquarters from one neighborhood to another as the occasion demanded. The project should be in charge of a full-time physician experienced in tuberculosis. As far as possible both the salaried staff and volunteers should consist of people who live in the area. Local cooperation and contribution to the effort should be sought actively.

With such a headquarters as a base, house to house, door to door and room to room campaigns can be made in areas where active cases have been reported. One approach would be to do a tuberculin test on each individual residing in the block in which a case of tuberculosis has been reported. Education must be continuous and purposeful. The people must be fully informed as to the purpose of the test. Here the use of volunteers from various racial and language groups would be most helpful.

A record of all positive reactors should be kept in the headquarters. Those who are found to have evidence of clinical tuberculosis should be referred to clinics or their own physicians. Tuberculin reactors who show no clinical evidence of disease should be treated with isoniazide right from headquarters. Here, close and prolonged follow-up can insure that as far as possible treatment is being followed.

The neighborhood headquarters would operate effectively in any of the large city congested areas. Particularly in Elizabeth such a neighborhood headquarters system could conceivably reduce the tuberculosis case rate radically within a very few years. The cost would be high but would be more than met by the savings in sanatorium care.

TUBERCULOSIS IN BETTER AREAS

IN THIS group tuberculosis is no longer a sanatorium disease. Most of these patients are being treated by their own physicians.

One of the important problems here is the traditional separation of tuberculosis from the main stream of medicine. Perhaps it is not

realized that this separation no longer exists. New cases of tuberculosis in the suburban population have become relatively few and these are diagnosed and treated by the practicing physician. Furthermore, since the advent of anti-microbial therapy, a high degree of therapeutic and clinical skill has become mandatory. This contrasts with the pre-antimicrobial era when the management of tuberculosis was a monotonous sanatorium routine of bedrest and pneumothorax refills.

At present only a few hospitals in Union County admit patients with a diagnosis of tuberculosis. General hospitals should admit newly diagnosed cases of active tuberculosis. Patients who are to go to the sanatorium may be transferred within a day or two. Those who are to be treated by their physician should remain in the general hospital for 2 to 4 weeks. This would give the practicing physician time to make use of all the facilities of a modern hospital, obtain experienced consultation, and establish the patient on an anti-microbial routine. Directors of education and attending physicians should include these patients in their teaching rounds.

In both suburban and city areas general practitioners, pediatricians, and others who see large numbers of children should do *tuberculin testing on all pre-school children*. Active cases of tuberculosis are often found in the environment of pre-school children who react to tuberculin. Furthermore, pre-school children who are tuberculin reactors should be treated even though they show no evidence of disease.

SUMMARY

1. There are two tuberculosis populations in Union County. They differ in economic status and in geographic distribution.

2. The patients comprising the lower economic group are found in the more congested areas of the cities, such as in Elizabeth, Linden and Plainfield. The others live mostly in the suburban areas and in the better neighborhoods of the cities.

3. Most of those tuberculosis patients who are hospitalized in the John E. Runnells Hospital for Chest Diseases are from the lower economic stratum. The members of the other population are largely under the care of private physicians.

4. These facts suggest the outlines of an eradication program. For the more congested areas it might be advantageous to employ an intensive eradication technic based on a neighborhood headquarters with neighborhood participation.

5. For the suburban areas there should be more support and encouragement of the practicing physician. Practitioners should be encouraged to bring their patients into a general hospital for the first 2 to 4 weeks of treatment, making available all the facilities of the hospital in addition to medical consultation. These cases should be discussed at rounds and at staff conferences. Hospital staffs must recognize that tuberculosis has become an integral part of medical practice. For the suburban population tuberculosis is no longer a sanatorium disease.

6. Despite the falling tuberculosis case rate and despite whatever efforts may be made to accelerate the decline, it seems most wise to plan on keeping a number of beds available for the treatment of Union County patients. These beds will continue to be needed for that tuberculosis population which comprises the low income group, has a high relapse rate and contains a large number of alcoholics. It seems that about 100 beds will be necessary to accommodate this group in the foreseeable future.

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Acute Renal Insufficiency in Obstetrics*

New Developments and Concepts

New "artificial kidney" apparatus offers new hope to victims of acute renal insufficiency; but as Dr. Slowinski here points out, more is needed than just the equipment.

In acute renal insufficiency excretory function is rapidly but temporarily lost due to alteration in renal circulation or direct tubular epithelial damage. Tubular degeneration results and selective reabsorption of glomerular filtrate is hampered, causing oliguria, hyperkalemia, and nitrogenous waste retention.

Precipitating factors (Figure 1) encountered in obstetrics are usually preventable. (1) Shock states are precipitated by incomplete abortion, ectopic pregnancy, placenta previa, abruptio placenta, postpartum hemorrhage, and ruptured uterus. (2) Pigment excretion is precipitated by hemolytic drug reaction and incompatible blood transfusion. (3) Nephrotoxicity results from sulfonamide, salicylate, or quinine sensitivity, mercurial abortifacients, septicemia, and probably, toxins of pre-eclampsia and eclampsia.

Oliguria follows the trigger incident, lowering daily urinary output below 400 cubic centimeters. Hematuria, proteinuria, and decreased specific gravity approaching that of the glomerular filtrate at 1.010 are associated findings. Lethargy, nausea, vomiting and diarrhea follow, and significant electrocardiographic changes of cardiovascular dysfunction with neuromuscular changes precede uremic coma and indicate hyperkalemia. Cardiac failure is the usual cause of death and hyperkalemia is second.

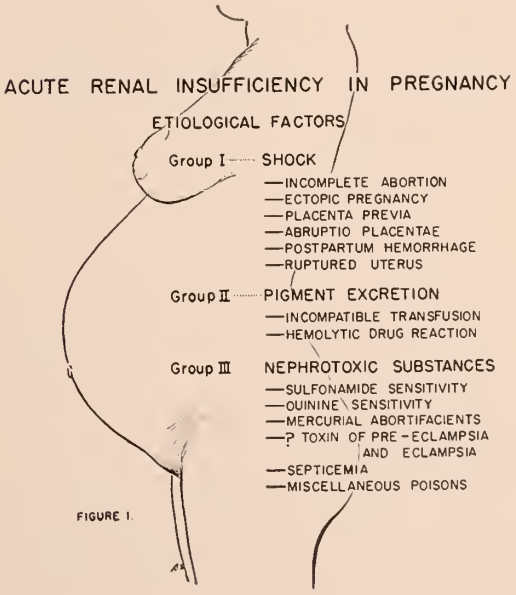


FIGURE 1.

Good antenatal care, prompt and adequate blood replacement to prevent or treat shock, and meticulous care to avoid transfusion reactions are cardinal principles. Drug or transfusion reactions can be detected early and minimized by alkalization of urine. Overhydra-

*Read before the Congress of the Pan American Medical Association in Mexico City, April 15, 1960. Dr. Slowinski is Assistant Director of Education (Obstetrics-Gynecology), St. Michael's Hospital, Newark, N. J.

tion must be avoided at all costs. Therapy is directed at maintaining fluid balance, preventing potassium intoxication, and treating infection until the body can regenerate the damaged tubular epithelium.

Body water needs are about 0.3 milliliters per kilogram per hour over visible loss in urine, sweat and vomitus. Prevention of body catabolism with insulin covered glucose infusions stops plasma potassium increase. Other sources of potassium such as protein-hydrolysates, duodenal replacement fluid and bank-stored blood are to be avoided.

Cation exchange resins given as 10 per cent retention enemas every six to twelve hours reduce plasma potassium levels.

All of these measures are available at any hospital. If they fail to maintain a patient, she should be transferred to a medical center where trained personnel can manage her with dialysis on the artificial kidney. *This is still the most important and successful method of reducing plasma potassium and nitrogenous wastes.* However, it is a difficult and time-consuming mechanism.

ETIOLOGY

Contributing, to some extent, in over one-third of the cases of acute renal insufficiency in obstetrics, toxemia is under heavy attack in current research and may soon be a forgotten chapter in our specialty. With the recent discovery by Hunter and Howard[1] of a pressor substance called *hysterotonin* in the decidua and amniotic fluid of toxemic patients, it appears that we may finally have come to grips with our adversary. Until now, therapy has been directed at alleviating the results of the basic pathologic change of toxemia but not towards the cause which has remained unknown to us. Perhaps in knowing our enemy we will better be able to eradicate him.

In the meantime, pharmacology has given us powerful aids to offset the hypertension, edema, proteinuria, and hyperexcitability of the nervous system. All may be caused by arteriolar vasoconstriction due to hysterotonin but each, as of now, must be treated separately.

The use of the new veratrum derivatives, Apresoline® and reserpine compounds, has made the attack on hypertension somewhat more successful than in the past. Chlorothiazide and its related substances are making diuresis a more predictable event. With the management of these major changes and of hyperexcitability and proteinuria, the pregnancy can be maintained to the point of viability where the ultimate "cure" of toxemia can be accomplished—emptying the uterus.

Thus, it is possible that toxemia, *per se* (and its major complications such as abruptio placenta) are somewhat preventable and quite treatable. By accomplishing these feats, at least one source of patients with acute renal insufficiency is becoming reducible.

What of *transfusions?* The Red Cross Joint Blood Council estimates that 9 per cent of all hospital admissions received transfusions of whole blood or packed cells during the year 1958. Over two million units of blood were used. When one considers this liberal use of such a potentially dangerous form of therapy, it is rather amazing that more cases of renal shutdown do not occur, especially in obstetrics where a large proportion of the transfusions are used. This is due to the precautions taken by our fine hospitals in the accurate cross-matching of blood. However, tragic accidents still occur and incompatible transfusions are sometimes given. Too often, this is due to the personal factor in incorrect labeling, confusion of names, improper identification of patients and inadequate and cumbersome storage technics.

Every advance in serologic technic is rapidly converted to practical application in the hospital to give every benefit of progress to our patients. It seems incredible, that after these efforts, we should lose patients to such complications as acute renal insufficiency from errors of judgment often made in haste by incompetent or irresponsible personnel in whose hands the responsibility of transfusion has, in some measure, been placed. Perhaps the old staff appointment of "Attending Tranfusion-

1. Bibliography furnished upon request.

ist" was dropped too quickly in our modern medical scheme after direct transfusions became obsolete. In this personality we had a physician of responsibility whose job it was to see that proper blood was given to the proper patient in the safest manner and with care taken to minimize or avoid any reactions. In the use of such a potentially dangerous substance, should we not all become our own Attending Transfusionists?

Most fatal reactions occur in patients who have received more than 200 milliliters of incompatible blood. It is entirely possible that some premonitory signs of hemolytic reaction could be detected long before this amount is run in if these are carefully watched for. One plan might be the routine drawing of small samples of venous blood early during transfusions, centrifuging them and observing the plasma for the red tinge hinting at hemolysis. This has been suggested especially for patients under anesthesia where the subjective symptoms of chills, lumbar pain, and headache cannot be appreciated. The early recognition of reactions and prompt discontinuance of the offending blood will help to reduce the number of cases of acute renal insufficiency.

DIAGNOSIS

THE often difficult differentiation of oliguria due to dehydration from anuria due to tubular necrosis is helped by the "infusion tolerance test." This procedure is to be used for the diagnostic problem case only.

To the patient whose urinary output is under 8 to 10 milliliters per hour, and whose blood pressure is adequate to maintain glomerular filtration pressure, 1000 milliliters of 5 per cent glucose in distilled water are given intravenously in 30 minutes while carefully checking the urinary output with an indwelling catheter. In dehydration, the output should increase dramatically to 20 to 30 milliliters per hour. A slight rise to 12 to 15 is not a positive result and this patient must be considered as having acute renal insufficiency.

We are all properly cautious of the limitation of fluid intake to the limits of body needs (0.3 milliliters per kilogram per hour) plus sensible loss due to urine, sweat and vomitus in cases of acute renal insufficiency. The liter of fluid used in the test can be tolerated even by the "shut-down" patient, but, of course, must be included in the sharp totaling of the daily intake.

ANTIBIOTICS

THE patient who has suffered the insult of renal shut-down must be protected from the ravages of infection. In the past, prophylactic antibiotics were used with the intention of preparing the body better to prevent or fight this complication. It is unfortunate, however, that statistics have shown we have lost more patients to terminal infections of one type or another from the group who were given antibiotics routinely than were lost from the group who received these medications only when a definable specific infection was diagnosed.

One of the findings of uremia is leucocytosis. This must not be taken as evidence of infection without other corroborating findings. The causative organism must be found, classified as to susceptibility, and treated with the appropriate antibiotic. Doses must be adjusted when used in the patient with acute renal insufficiency. These medications are excreted to some extent by the kidney. In the group of antibiotics, streptomycin and Kanamycin® must be used cautiously, realizing high blood levels will be found for 10 to 14 hours on a dose which would last about 4 hours in a normal subject.

NEW APPARATUS

DISPOSABLE artificial kidney apparatuses are now available commercially. It has thus become economically possible for most general hospitals to own these instruments. Still needed are superior clinicians to run it, excellent laboratories to back it up, and high caliber hematologic, metabolic, urologic and anesthetic consultants necessary to counter the myriad prob-

lems which beset such patients. These desiderata should be met before any hospital administrator decides to purchase this "prestige item" —the machine proper.

The dependability of modern transportation, even for the seriously ill patient, has been proved by experience. Transfer of the anuric patient to a major center where these facilities for dialysis are available still seems to be the 'better part of valor." Transfer of such a patient should be made on the third or fourth anuric day so that a planned dialysis can be accomplished if necessary while the patient is in a relatively stable and satisfactory condition, not as a "last resort" attempt at life saving—all too often doomed to failure.

306 High Street

Defective Stethoscopes

The following is abstracted from the July 7, 1961 issue of *Medical World News*:

Stethoscope detective Dale Groom has been out borrowing his colleagues' listening tubes again. This time he discovered that most stethoscopes aren't really giving out much sound.

Several years ago, Dr. Groom, assistant professor of medicine at the Medical College of South Carolina, began to study ears and earpieces. Much of the time, he observed, the two are not very well matched. Sometimes, in fact, the curvature of the ear completely blocks off the hole in the earpiece.

Now he has demonstrated that hospital noise drowns out the noise in the stethoscope; a grade I heart murmur in a ward turns out to be really a grade II murmur if heard in a soundproofed examining room, according to Dr. Groom. Furthermore, after 150 years, the stethoscope itself is so unstandardized that in many cases it is "virtually useless for anything other than checking blood pressure or listening to loud bowel sounds."

For the average stethoscope, a heart murmur would have to be five times louder than it really is for the examining physician to hear it.

"By correcting the gross defects in the instruments, we got an average improvement of over 300 per cent."

Most stethoscopes, according to Dr. Groom, are too long "for efficient transmission of sounds. Ideally, they should be no more than a few inches long, but a practical length is 20 inches over-all. In many instances, the internal diameter of the tubing is too large; an internal diameter of 3/16 of an inch is a good compromise. We found that soft gum rubber tubing admits much extraneous noise, but we got significant improvement by replacing such tubes with plastic or thick-walled rubber tubes."

The worse fault of most stethoscopes, however, is leaks—leaks in the earpiece, leaks in the tubing, leaks at the change-over valve, leaks at the chest piece. Even small leaks can cause major losses and much interference from extraneous noise.

Some leaks, he points out, can be found simply by blowing into the instrument. More difficult is the problem of leaks caused by the fact that the earpiece doesn't fit the ear. "We have found remarkable variations even in the ear of a single person—variations in canal diameter, angle and elliptical contour. It appears that much could be gained by experimenting with the individual fit, in selecting the earpiece for size and in adjusting the angle, direction and pressure of its insertion."

Then, there is the problem of outside noises leaking into the stethoscope. This involves what physicists call "signal to noise ratio," says Dr. Groom. The noise you are trying to listen to has to be louder than the noise you don't want to hear. Lowering the level of the "interfering" noise gives you a better chance of hearing the "signal" noise.

Jack R. Karel, M.D.

Hillside

Doctors, Druggists and Turmoil

This outspoken piece reflects one man's view on what to do about the rising tide of new pharmaceuticals. Dr. Karel, of course, speaks only for himself, and comment from readers is invited.

Turmoil in the pharmaceutical industry has reached a point where we physicians must take a forceful stand and come to the assistance of the neighborhood pharmacist. If conditions continue as they are in the research, manufacture and distribution of drugs, the physician will suffer the eventual consequences. Patients complain about the high cost of medicines. Pharmacists are getting gray hair watching the accumulation of boxes, bottles, tablets and capsules on the shelves in their stores. Frankly, how many of us, as doctors, take the trouble to inspect the area where pharmacists compound their prescriptions for their patients? Such inspection might shock us. It is time we doctors began to assist the pharmacists. By helping them, we will be helping ourselves. Pharmacists are in a turmoil as to what to do with the shelves loaded with obsolete and unsalable drug products dispensed by prescription only—with many more coming. The cost of all this is enormous and must be borne by the pharmacist at a great loss, or passed on to John Q. Public.

Many pharmaceutical companies make similar drugs, for example, the antibiotic tetracycline. After a time the chlorine was removed and two other preparations appeared. One contained citric acid and the other did not. Each was marketed under a different tradename. The citric acid was supposed to increase the absorption of the antibiotic. After another brief lapse of time, another change is made. This one is called demethylchlortetracycline. It is about three times more potent than tetracycline against susceptible organisms, has greater stability in body fluids, a low order of toxicity and a lower rate of renal clearance. It is supposed to supply continuously high antibacterial effectiveness for at least one full day after dosage has been discontinued. With such a wonderful description one would imagine that the early forms of tetracyclines would be withdrawn; but that does not happen.

Another company started out with oxytetracycline and later also introduced tetracycline. After a time, along comes an improvement: the addition of glucosamine. It is asserted that this addition potentiates the tetracycline for higher oral-dosage blood levels. Again the tradename changes.

If these chemical changes were such major improvements, why were the older versions not withdrawn and the doctors notified accordingly? This seldom occurs. You need only to open the 1961 *Physicians' Desk Reference** to find that the older products are still being described. The argument is that many doctors write prescriptions for the older preparations. Thus, the pharmacist must carry a stock of every type and color. But why should that

*Physicians' Desk Reference, Published by Medical Economics, Inc., Rutherford, N. J.

obsolete product with lesser activity continue to be marketed and detailed to the physician?

Another problem is produced by "cross licensing." This means that a company other than the originator may manufacture and market *the same product under another tradename*. Let me cite one instance: the antibiotic potassium phenethicillin. It originated in England. Six pharmaceutical companies in the United States were licensed to manufacture it, each under a different tradename. Furthermore, it is prepared as a tablet, for oral solution and as a pediatric drop. A drug store must carry 18 different packages of potassium phenethicillin. Our country encourages free enterprise and competition which I heartily favor; but not to the point where the general public must bear the burden of unnecessary increased cost of medicines or where the pharmacist assumes unnecessary losses. In my opinion, the government should not permit different tradenames for the same drug.

A CERTAIN chemical was developed which reduces blood pressure and increases renal flow. The preparation is distributed in tablet form in six strengths and I shall call it by the letter A. Another preparation, B, is introduced and said to be an improved version of a known diuretic. The two are now combined to produce a third compound, C, an improvement over A and B. In the meanwhile, another antihypertensive, D, appears with the added features of a calming agent. But the older versions still lie on drugstore shelves. A is combined with D to produce E—having a more marked effect. D is then combined with B to produce F—which combines in one tablet the antihypertensive heart-slowing and calming effects of D with the diuretic and antihypertensive-potentiating effects of B. Now comes G—a mild stimulant and antidepressant that is combined with D to produce an emotional stabilizer. If that isn't enough, the finale is H—a combination of G and B. All these preparations are in tablet form, in various strengths and from one company. If this is confusing to the reader, how do you think the pharmacist must feel, carrying such a financial burden? How gullible does he think the medical profession is? These flagrant examples probably can be multiplied a hundred-fold.

What then is the solution to this serious problem? Shall we wash our hands of the mess and say it is not ours to correct and write for every product manufactured regardless of how it affects the pharmacists? Shall we leave it for someone "higher up" to solve? No, it is our problem and medical societies and individual doctors can correct this situation.

First, ethical, reputable, pharmaceutical companies should be put on notice that promiscuous elaboration and distribution of drugs be discontinued.

Second, if a company releases without doubt and with adequate clinical trial an improvement over a previous drug marketed by them, then the latter should be swiftly withdrawn from the market. The company should not wait until demand for it produces little return.

Third, we doctors should refrain from prescribing drugs that have been produced and packaged under a private name which are copies of those developed by known ethical, reputable pharmaceutical companies. This is a serious heartache to the ethical pharmacist.

Fourth, where several pharmaceutical companies have marketed the same product under a different tradename, the doctor should not specify a specific brand, but use the accepted letters, A - R - B, meaning "any reliable brand."

115 North Avenue

NOTE: For a somewhat different view, see the editorial on page 489 of this JOURNAL.

J. Lloyd Morrow, M.D.

Passaic

Physician's Dilemma: Psychotherapy*

Role of the Psychologist and Psychiatrist in Treatment

Many non-physicians are doing psychotherapy. Dr. Morrow feels that, to some extent, this is the fault of referring physicians—and here makes a plea for limiting unsupervised psychotherapy to the psychiatrist.

Emotional and mental disturbances have become one of the most extensive of our public health problems. Total therapy, including preventive as well as remedial measures, involving every medical and psychologic method is the accepted procedure today. The medical profession has found it therapeutically advantageous to refer many of its patients for psychotherapy. The problem of referral, however, has led the profession into a disconcerting situation. The physician has suddenly found himself involved in trying to establish the exact relationship of the psychiatrist and psychologist in the psychotherapeutic picture.

Psychologists have been integrated in great number into most of our welfare services wherever psychiatric services are required. They are functioning in diagnostic and therapeutic roles in which, in my opinion, they have no ethical or professional right.

This tremendous influx of psychologists into a situation which is basically a medical one, plus increased demands in the clinics, hospitals and private offices for trained mental health personnel (which includes social workers and ministers, as well as psychologists) has made the referring physician's problem more difficult. Adding to this confusion is a controversy between the psychologist and the psychiatrist as to who should be basically responsible for psychotherapy. Unwitting or no, psychologists have begun to claim psychotherapy for their own. Yet the treatment program is fundamentally a medical one that belongs under the purview or control of the psychiatrist. Simply stated, "psychotherapy is a form of medical treatment."

As a matter of fact, a joint resolution† drawn up and adopted in 1954 by the American Psychiatric Association and the American Psychoanalytic Association and recognized by the American Medical Association specifically emphasizes the medical responsibilities of the psychiatrist. This resolution makes it clear that the application of psychologic methods to the treatment of illness is a medical function and that psychotherapy is a form of medical treatment.

The American Psychiatric Association[1] notes that "it is a basic tenet of modern medicine that the psychological and physical components of an illness cannot be separated in diagnosis and treatment. At any point in a disease process, psychologic symptoms may give rise to, substitute for, or run concurrently with

*Read at the February 17, 1960 meeting of the Society of Clinical Psychiatrists of Northern New Jersey, Hackensack, N. J.

†This was published page 228, May, 1961 Journal.

1. American Psychiatric Association, March 7, 1954. Statement of position on proposed amendments to medical practice acts. Washington 9, D.C.

physical symptoms, or *vice versa*. Therefore, psychiatry is opposed to the independent isolated treatment of psychologic symptoms by non-physicians. Some non-physicians, notably clinical psychologists, are trained and competent to administer psychotherapy; but it is psychiatry's contention that they should do so only in hospitals, clinics or other settings where adequate psychiatric safeguards exist and where medical responsibility for the diagnosis and treatment of the patient is clearly established and continuously present."[1]

The psychologist, despite his exposure to psychiatric treatment technics and however long his experience in his field, cannot with justification and reliability make a final diagnosis. He might make a partial deduction of the presenting psychologic patterns; but his findings must necessarily be incomplete unless he has access to the wide array of physico-chemico-biologic structures of which his subject is composed.

It is not necessary to delineate all the differences between a psychiatrist, a psychologist and a social worker; but the medical profession should know what each does in the complicated sphere of mental and emotional illness. It may suffice to say that only the psychiatrist has the knowledge to evaluate the individual as a whole, psychically and somatically; and for that reason he is entrusted with the moral and legal responsibility for such patients by society and the law. In the eyes of the law, the psychologist and social worker who give testimony are no more considered experts in human behavior than are the lawyer, the minister, the teacher, or the police officer.

The psychiatrist is first, last and always a physician. His approach may be psychotherapeutic, but his armamentarium embraces clinical objectivity and experience. He has been exposed to sick people for at least fourteen years and his certification is based upon an intensive familiarity with organic neurologic principles. Experience has often made him wary of either laboratory or psychologic tests. His medical mental wheels may be grinding out exclusion of hyperthyroidism, porphyria, Cushing's disease, and brain tumor at the same time that he is evaluating ego strength and conflict patterns. He may be assessing the aspects of the family physician's effects on the patient and what can be done to elaborate these more effectively. Or he may even be thinking that the patient is treatable by a reliable psychologist with adequate supervision. And, as any physician, he will consider consultation with others more skilled than he, in a manner of participation with a colleague, with the feeling of understanding and speaking the same language in the same land. This is the reason that a psychiatrist is given the responsibility of the diagnosis of a mental disorder by the law.

Both the psychiatrist and the psychologist have borrowed heavily from the experience of psychoanalysis and clinical observations of man in sickness and in health, to formulate the body of scientifically validated principles which is called the "psychotherapeutic treatment." This means that under specific circumstances a transaction operates between a therapist and an individual in the direction of helping the patient to change or to accept himself in the light of self-discovery, thus lowering the painful state of tension for which he sought help.

Psychotherapy is the practice of influencing man's thinking, feeling and behavior by psychologic means. It is only one form of mental healing. Surgical treatment responds best when the patient derives special gratifications from his personal interaction with his surgeon. Medical states, such as diabetes, colitis and the like, improve better with a helpful, harmonious doctor-patient relationship. The penitent derives benefit from certain contacts with his religious leaders.

Felix[2] states: "There are others who possess the ability to diagnose and treat the physical aspects of the problem; there are still others competent to identify, modify and improve specific psychologic and sociologic com-

2. Felix, R. H.: Presidential address delivered May 8, 1961, before the Annual Meeting of the American Psychiatric Association in Chicago.

ponents underlying the onset and the course of mental disorders. But only the psychiatrist is expected to bring together in one person knowledge and technical ability in all of their fields."[2]

A MORE pertinent reason for questioning the competence of the non-medically trained psychotherapist is the limitation and danger of the treatment itself. Psychotherapy is only one form of treatment for mental disorder; and this is effective and safe only when a trained and competent psychotherapist works with a suitable patient. The applicability of psychotherapy to the psychotic patient is frequently questioned since unrestrainable "acting out" and irreversible psychosis are not infrequently seen. The general rule nowadays is to use the newer drugs for these states and to maintain treatment with a ready hand for medication. Some of us feel that depressions that last too long, apart from their suicidal import, tend to 'condition" the individual more readily for later depressions in contrast to the opposite on shortening the depressive reaction. With the neurosis and character disorders (except in the most mild) it is generally felt that drugs do *not* interfere with therapy as much as was formerly thought. Thus, some patients even in psychoanalysis are now being given selected drugs with benefit. Many of us feel that pure psychotherapy (as was formerly practiced almost exclusively) is not entirely the *sine qua non* of rational therapy.

As David[3] so aptly noted, effective psychotherapy is based on knowledge about health and disease and their various manifestations. A medical training is valuable not only in differential diagnosis, but also because it provides a degree of comfort in the psychiatrist because he knows about physical illness. "Psychotherapy is not just counseling or guidance, it is chiefly concerned with personality disabilities or misinterpretation. Treatment is for the whole patient not just the specific mental problem."[3] White[4] also emphasized this when he said, "Psychiatry . . . demands for its background the whole of medicine, because . . . it deals with the whole individual . . . So the psychiatist is a specialist in the reactions of the organism as a whole, and those reactions he cannot understand unless he knows all parts of the organism . . ." It is the psychiatrist, alone, who is concerned with mental illness, and who is equipped to evaluate and assume responsibility for the care of the total patient.[4]

I would like to go one step further in emphasizing this rather obvious fact which seems so badly neglected and about which most physicians seem unaware. It concerns the competency of the non-medically trained mental healer—the psychologist. He offers psychologic tests and although he purports to see psychologic principles more clearly than the psychiatrist, he can only promise to seek medical consultation where he thinks it may be indicated. Here is where the danger and possible hazard to the patient lies.

The pseudo-security of a patient under the care of a non-medical therapist is a betrayal of the patient's trust. Whether or not the psychologist states to his patient (or client) that he is *not* a medical man, he unwittingly perpetrates a fraud upon someone who looks up to him for help by fostering those elements of denial of physical factors which may well be progressive and irreversible.

When a suffering patient seeks help from a questionably qualified practitioner, he is putting himself in that practitioner's hands in the hope of gain in terms of health or some other reason. Whether the psychologist tells him he is or is not a physician, that patient is seduced into believing that his health will be safeguarded or improved. A practitioner who does not know what he doesn't know betrays a patient's trust as surely as if he were doing this with premeditation.

Psychiatrists are not engaged in a partisan struggle with competing professionals but are the most qualified representatives of medicine to evaluate the practices of psychologists and do so in the best public interest. We would say with the ophthalmologists that when the op-

3. David, C. B.: Diseases of the Nervous System, 22:106 (February 1961).

4. White, W. A.: American Journal of Psychiatry, 5:1 (July 1925).

tometrist becomes a physician, or with the internist when the laboratory technician becomes a physician, when the psychologist becomes a physician we will consider his specialized knowledge as acceptable in the public interest.

The psychologist is not expected to have medical skill. However, one profession does complement the other through cooperation and working together psychologically and sociologically. The interest of the psychologist and the psychiatrist coincides—for their mutual benefit in the same end product—the improved patient.

In the establishment of the psychiatrist's position in New Jersey, two recent events are of importance. When the New Jersey Mental Health Law came into being, Ira Ross, then president of the New Jersey Neuropsychiatric Association, won acceptance of the principle that State funds would not be given to any psychiatric clinic unless a psychiatrist was responsible for the diagnosis, treatment, and supervision of its patients. In the recent bill regulating the examination and management of emotionally disturbed children in schools, members of the N. J. Neuropsychiatric Association were instrumental in placing the final responsibility for the instrumentation of the act on a physician, preferably a psychiatrist.

New York State has a "certification act" in which the psychologist is autonomous and responsible to no one except himself and his conscience in the psychotherapeutic care of his patient. New York is only now changing its laws concerning midwifery, requiring the midwife to be responsible to a physician. That State attributes its former policies to a lack of obstetricians. Several other states (including California and Michigan) define psychotherapy as part of the practice of medicine.

Psychotherapy must be clearly defined as "those efforts by medically responsible individuals to influence, maintain and cure mental illness, the major psychoses and the neuroses, psychosomatic conditions and character neuroses, by mental means." It cannot be distorted or camouflaged by replacing it with terms such as "guidance" or "counseling," nor by relabelling the patient a "client."

Psychology is only one form of investigation and understanding of mental illness. It is only one of the many tools of the armamentarium of psychiatry and the application of its insights is a medical function.

Psychologists are neither educationally nor professionally competent to conduct psychotherapy independently. Their function should be restricted to "the application of established principles of learning, motivation, perception, thinking and emotional relationships to problems of personnel evaluation, group relations and behavior adjustment; and the application of these principles should include measuring and testing personality, intelligence, aptitudes, emotions, public opinion, attitudes and skills, and doing research on problems relating to human behavior."

A psychologist should do psychotherapy only under the constant and vigilant supervision of a psychiatrist. Of all concerned with mental illness, only the psychiatrist is a physician. Responsibility for evaluating the whole patient (physical, psychologic and social) and for therapy, conducted or prescribed, rests on him. Psychiatrists, "by education and commitment" . . ."are practitioners of the healing arts while giving particular attention to psychologic medicine."[2]

We thus would like to make this plea to the medical profession. By not being aware (or inadvertently through a lack of vigilance) the profession is permitting many State services to go unchallenged and is unwittingly abetting the practice of having their patients treated by unqualified and unresponsible persons. The question or referral for psychotherapy boils down to one essential—for safety and for adequate medical treatment—only the psychiatrist can be entrusted with your patients.

197 Passaic Avenue

Milton Shoshkes, M.D.
Louis J. Levinson, M.D.
Bertram Levinstone, M.D.
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Newark

Thirty Years of Experience with Malignant Lymphoma*

At the Newark Beth Israel Hospital

Although x-rays, nitrogen mustard and corticosteroids have not appreciably boosted survival from malignant lymphoma, the palliative effects make these modalities seem worthwhile.

Since 1938 the Tumor Clinic at the Newark Beth Israel Hospital has been under the direction of one of us (L.J.L.). This has allowed a uniquely unified program of therapy throughout 23 years. With this passage of time certain changes in the treatment of the malignant lymphomas have occurred. Besides radiation therapy, chemotherapy with alkylating agents of the nitrogen mustard group and the adrenal cortical steroid hormones have been introduced to this clinic as initial favorable reports appeared in the literature.

There is now a need to review our experience with the malignant lymphomas to evaluate the therapy and to compare our cumulative experience with that reported elsewhere. We realized that there would be difficulty in obtaining a complete follow-up, especially in private cases, since there was no central agency at that time, such as the Central Tumor Registry, which was founded here only 5 years ago. We knew that there would be great difficulty in re-establishing contact with many of the patients treated in the earlier years of this retrospective study since the long time interval allowed for the moving away by some, the unreported deaths of still others, and the dissolution of several physicians' offices through death or retirement with subsequent loss of records. Nevertheless, the potential value of such a study (especially as it afforded an opportunity to review the salient clinical features of these cases) outweighed these deficits.

METHOD

The records of all patients seen at the tumor clinic and treated with x-radiation at the Newark Beth Israel Hospital were the primary sources. These records were cross-indexed according to basic disease. Those filed as malignant lymphomas were reviewed. The in-patient charts of all of these patients hospitalized here were obtained. All available ab-

*Read May 17, 1961 before the Joint Meeting of Ophthalmology and Medicine of The Medical Society of New Jersey. The authors are indebted to Irwin Roseff, M.D., formerly Assistant Resident in Medicine for assistance during the initial phases of this work.

stracts of treatment records from other institutions plus information from the offices of private physicians were used to supplement this information pool. A direct mailing of a questionnaire to the private physicians and institutions involved was utilized to complete the follow-up data concerning the last known condition of the patient. Critical screening of these cases necessitated confirmation of their disease as proved by surgical biopsy. *No cases were included without biopsy proof* no matter how suggestive the clinical course. In multiple biopsy cases, the last recorded positive diagnosis was accepted. The data were deficient in the survival follow-up. Since those lost to follow-up were too many to be disregarded, it was decided that those lost to follow-up (after varying intervals of medical supervision) were to be interpreted as mortalities at the time of their disappearance. For example, a patient might be treated in the clinic and during several hospitalizations for an observation period totaling four years and then fail to return for follow-up examination despite several written requests. Such a patient was deemed dead after four years of observation. This interpretation increases the mortality rate and lowers the average survival age for each group analyzed; but it is the most conservative way of handling the data. Despite these compromises, 32 cases were lost to scrutiny so soon after their initial treatments, that it would be inaccurate and unjustified to include them in this series as a treatment result. They were discarded. For example, some disappeared shortly after a few radiation treatments without the benefit of a full therapeutic course to even a single portal of exposure. However, the importance of this analysis lies in the value of the clinical data now to be presented, much vital information concerning the nature of malignant lymphoma as it appears when first diagnosed, and the clinical course during the treatment years.

A total of 168 cases fulfilling the criteria of biopsy-proved malignant lymphoma, treated between the years 1930-1959 (Table 1) were analyzed. The data varied somewhat in completeness, depending upon the carefulness of the recorded history of the referring physician. Fortunately, we were able to supplement the data in most of these referred cases by a personally obtained history and physical examination prior to the onset of therapy. All radiation therapy data was recorded in detail.

TABLE 1.

HISTOLOGIC TYPES

Hodgkin's disease	84
Lymphosarcoma	54
Giant follicular lymphoblastoma	22
Reticulum cell sarcoma	8
	168

RESULTS

Population Characteristics: There were 98 males and 70 females. A most unexpected finding was the enormous disparity between the races: 164 were white and only 4 were Negro. This unexpected ratio is out of keeping with the experience in all of the other clinics and services in this hospital in which about 50 per cent of the population is Negro.

Age at Onset of Symptoms: Symptoms appeared in every decade from the first through the eighth as demonstrated in Table 2. Incidence increases with each decade to a maximum in the fifth decade. Nearly two-thirds of this group began their illness in the middle years between 30 and 60.

Histologic Types: Table 1 differentiates the types of malignant lymphomas analyzed.

TABLE 2.

AGES AT TIMES OF ONSET AND TIME OF DIAGNOSIS

Age (In Years)	At Onset of Symptoms	At Time of Diagnosis
0 - 10	5	5
11 - 20	12	10
21 - 30	22	18
31 - 40	25	30
41 - 50	39	39
51 - 60	35	35
61 - 70	22	21
71 +	8	10

Eighty-four were classified generally as Hodgkin's disease. No attempt was made to subdivide the group into paragranuloma, granuloma or sarcoma types. Fifty-four were classified as lymphosarcoma; the remaining general classifications were the giant follicular lymphoblastoma (22 cases) and the reticulum cell sarcoma, numbering 8. In other analyses reported in the literature, these latter two groups have been totaled together with lymphosarcoma *per se*. Since these latter entities can be delineated by histologic interpretation (and have always been so treated at this hospital) they were analyzed as separate groups.

Age at the Time of Diagnosis: These figures show very little difference (Table 2) compared to those of the previous group. There is a shift of the age incidence to the slightly older brackets as might be expected since there is often a time lag when confirming a diagnosis after the onset of any symptoms. In most instances, the age groups were the same, with the symptoms of onset preceding a diagnostic biopsy by a few months only. In a few cases, however, several years elapsed before a diagnosis of malignant lymphoma was established.

Presenting Symptoms and Physical Signs: These were usually multiple and in varying combinations involving nearly every organ system in the body. Table 3 lists these observations by frequency. Approximately one out of three presented a palpable mass. Symptoms of systemic disease were found next most frequently. These included weight loss, anorexia, malaise and fever. Pain occurred in the area of disease in one-quarter of our group. Anemia appeared frequently. When the lungs were infiltrated, cough, dyspnea and often hemoptysis were observed. Pruritus, which is frequently described in Hodgkin's disease, appeared in only five patients. The remaining symptoms and signs occurred infrequently. Their wide variety re-emphasized the unpredictable patterns of symptoms and signs. Symptoms and signs varied according to the sites and number of organ systems invaded by the tumor tissue.

Areas Involved at the Onset: The lymphoid tissue of the body was by far the most commonly involved (Table 4). Cervical nodes were the most frequently diseased, appearing in 54 per cent of the group. Inguinal and axillary nodes were next, but were implicated in less than half the frequency of the cervical nodes. Splenomegaly and mediastinal node invasion were found somewhat less often. The liver was the next most frequently involved visceral organ. Pulmonary parenchymal involvement was separated from hilar node enlargement in this analysis and, surprisingly, the peripheral lung tissue was the more frequently invaded. Bone invasion and gastrointestinal involvement were only slightly more

TABLE 3.

PRESENTING SYMPTOMS AND SIGNS AT ONSET AND DIAGNOSIS (Combined)

1. Mass	59	20. Wheezing	2
2. Weight loss	44	21. Hoarseness	2
3. Pain	43	22. Leukocytosis	2
4. Anorexia	36	23. Dysphagia	2
5. Malaise	35	24. Tarry stools	2
6. Fever	33	25. Diplopia	2
7. Anemia	24	26. Colds	2
8. Cough	20	27. Clubbing	2
9. Sweats	17	28. Lacrimation	2
10. Dyspnea	12	29. Petechiae, Horner's syndrome, Priapism Vomiting, Dizziness, Arthralgias, Tonsillar enlargement, Epistaxis, Photophobia, Cyanosis, Ascites, Orthopnea, Deafness, Pyrosis, Superior vena cava syndrome—1 each.	
11. Chills	9		
12. Hemoptysis	7		
13. Pruritis	5		
14. Nausea	3		
15. Pleural effusion	3		
16. Edema	3		
17. Rash	3		
18. Abdominal distention	2		
19. Nasal obstruction	2		

TABLE 4.

COMPARISON OF THE TEN AREAS MOST COMMONLY INVOLVED AT ONSET AND DIAGNOSIS

	At Onset of Symptoms	At Time of Diagnosis
Cervical nodes	91	102
Inguinal nodes	37	54
Axillary nodes	36	56
Mediastinal nodes	20	34
Spleen	25	28
Liver	17	22
Bone	11	20
Lung	16	19
Hilar nodes	12	18
Gastro-intestinal	8	8

frequently noted than periorbital tissues. The remaining sites signify merely the random locales of the haphazard lymphomatous deposition.

Areas Involved at the Time of Diagnosis: In our series, the time of diagnosis is also the time of onset of therapy. Involvement of the lymphoid tissue noted previously was now observed to increase in frequency for each of the previously described sites, but maintaining with little change the already delineated descending anatomical locations (Table 4). Diseased cervical nodes were now found in 61 per cent of the patients while axillary and inguinal nodes were each seen in 33 per cent. In the short interval between the onset and diagnosis, mediastinal involvement appeared in 14 more patients, with similar surprising increases in involvement of bone, hilar nodes and epitrochlear nodes. Of the rest, a smaller ratio of increase in the number of patients showing involvement in previously described sites was seen. It was impressive to observe the rapidity with which spread appeared, especially in the new sites of previously apparently normal lymphoid tissue.

Survival from the Time of Diagnosis: Outlook for survival from malignant neoplastic disease is always grim. This series gave added confirmation that the diagnosis of lymphomatous malignancy foretells an ominous outlook no matter how intensive the treatment regimen or how minimal the original involvement. Deaths occurred in a significant percentage within the first observable three months after the diagnosis was confirmed, with a progressive accumulation of mortality in a steady manner. At the end of five years, the mortality rate was as follows: 84 per cent of the Hodgkin's cases; 83 per cent of the lymphosarcoma cases; 83 per cent of the reticulum cell sarcoma cases and 72 per cent of the giant follicular lymphoblastoma cases. (Table 5) Hodgkin's cases average 24 months,reticulum cell sarcoma cases 27.2 months, and (the longest survival of all the groups) giant follicular lymphoblastoma average 54.6 months. Although the 32 cases lost to follow-up make their loss felt in these figures, the random

TABLE 5.

AVERAGE LENGTH OF SURVIVAL FROM THE TIME OF DIAGNOSIS AND THERAPY

1.	Hodgkin's disease	34.0 months
2.	Reticulum cell sarcoma	27.2 months
3.	Lymphosarcoma	26.9 months
4.	Giant follicular lymphoblastoma	54.6 months

nature of their losses allows us to render a fair judgment on the remaining 136 patients since these cases were not omitted by any subjective design or plan. All those lost to follow-up after some maintained therapeutic program was instituted were considered "dead" at that time, for these statistical purposes. These averages, therefore, have been calculated in the most conservative way possible.

Modalities of Therapy: All received x-ray therapy as the original condition for their selection for this evaluation. Table 6 separates the various combinations used as well as the x-ray.

TABLE 6.

MODALITIES OF THERAPY

1.	X-ray alone	126
2.	X-ray plus alkylating agents	31
3.	X-ray plus alkylating agents plus steroids	8
4.	X-ray plus steroids	1
5.	X-ray plus surgery	1
6.	X-ray plus surgery plus alkylating agents	1

Until 1959 (when Cobalt 60 teletherapy became available to us) all cases of malignant lymphomas were treated by orthovoltage x-ray therapy. The factors used were 200 and 250 K.V., with half-value layers of one to two and one-half millimeters of copper and a target skin distance of 50 centimeters. All doses were measured as roentgen units (r) in air. Exposure dose could then be readily converted into actual tumor doses in roentgens by referring to depth dose tables prepared for each quality of x-radiation. The actual total exposure dose varied, depending on the localization of the disease and the number of fields required. Where a single area was involved, and one field technic could be used, total exposure doses of 2000 to 3000 r were admin-

istered in one series, using daily increments of 150 to 300 r. Where several fields were necessary for the treatment of multiple sites of involvement, maximum total doses of 600 to 1000 r were given to each field during one course of therapy. Most patients in this study received one to four separate courses of x-ray therapy; some received 20 or more. Maximum aggregate dose given to one single region varied considerably; but most of the patients received maximum single field doses of 1000 to 3000 r with a small number reaching totals of 4000 to 5000 r.

In 30 patients, alkylating agents of the nitrogen mustard group were added. Mechlorethamine (HN_2) was preferred over triethylenemelamine (TEM) by a 3 to 1 ratio. In eight others, adrenal cortical steroid hormones (cortisone, hydrocortisone and prednisone) were added to the combination of alkylating agents and x-rays. Surgical excision was used for definite therapy rather than merely biopsy in two patients; one also received x-ray therapy, and another, x-ray and nitrogen mustard therapy. The remaining patient received adrenal cortical steroid hormone as an adjunct to x-ray therapy.

Following biopsy, x-ray was used to treat localized areas of disease. When systemic symptoms became an intractable problem or when the spread of disease involved too many sites, the alkylating drugs were used. The patient was usually hospitalized for nitrogen mustard administration. Ambulatory courses of triethylenemelamine were rarely given. Adrenal cortical steroids were used to treat these same systemic symptoms primarily as an adjuvant therapy to the out-patient department program. Our experience with these multiple treatments was similar to that generally reported, in that initial symptomatic and objective improvement could be obtained with all of these modalities of therapy. Remissions could be induced on at least single, and at times with multiple courses of the above modalities, even to the point where a gratifying remission occasionally could be produced for up to several years observation. Ultimately, however, resistance to all treatment modalities occurred. Death ensued for the overwhelming majority, long before the fifth treatment year.

Six patients survived more than 10 years. These are summarized in Table 7. Four survive to this writing, two of whom had lymphosarcoma, and two giant follicular lymphoblastoma. The two with Hodgkin's disease died despite survivals of 13 and 15 years respectively. All were white, and all but one were males. Radiation therapy was used in all; only one case, a Hodgkin's disease, received added chemotherapy which consisted of both nitrogen mustard and TEM. All of those who survived (ranging in duration from 10 to 14

TABLE 7.
THE LONG-TERM SURVIVAL CASES

Case No.	1	2	3	4	5	6
Diagnosis	Lympho-sarcoma	Lympho-sarcoma	Hodgkin's Disease	Hodgkin's Disease	Giant Follicular Lympho-blastoma	Giant Follicular Lympho-blastoma
Sex	M	M	M	M	M	F
Present Status	Alive	Alive	Died	Died	Alive	Alive
Duration of disease (years)	11	14	15	13	15	14
Age of onset (years)	29	13½	16	13	45	34
Radiation therapy courses	1	3	7	36	2	3
Maximum r to A single port	3000	550	2650	6850	400	2200
Chemotherapy courses	0	0	0	5	0	0
Duration of remission (years)	10	12	0	0	14	11

years) are apparently free of active disease. The one point in common among these survivals is the radiosensitivity of the tumors. A single course of radiation therapy sufficed Case 1; only two courses for Case 5; while Cases 2 and 6 received only three courses. These ranged in intensity, as measured by the maximum delivered to a single portal, from only 400 to 3000 r. The Hodgkin's disease cases (3 and 4) received much more radiation. Case 4 needed 36 courses including a maximum portal dose of 6850 r plus the chemotherapy, before succumbing after his 13-year battle.

COMMENT

THIS series is similar in many respects to other surveys published. Males also predominate [2] in these cited reports,[3] while race differences have also been noted previously by Hoster and Dratman,[4] who found that Hodgkin's disease was less common in the Negro. Minot and Isaacs[5] in their report (34 years ago) noted the age incidence to be similar, with the highest numbers generally between 30 and 60 years.

The tabulated presenting signs and symptoms we have reported here echo again the findings of other investigators.[1,2,3,5,6] These can be summarized by description of the typical patient. Such a patient would present himself with an enlargement of some regional lymph node groups in the cervical chains. Often these nodes would be painful and tender. Added to this would be the systemic symptoms of fever sweats, anorexia, weight loss and weakness. Since lymphoid and reticuloendothelial cells are widely distributed throughout the body, there is no area immune to the primary or the secondary appearance of disease.[1] Other symptoms and signs would be dependent on the areas involved.

Although there was a minimal time lag between the time of onset of symptoms and time of confirmation of diagnosis, there was, nevertheless, a rapid increase in the number of sites involved during this interval. This acceleration was, for many, a prediction of the downhill course to come. This rapid increase in the number of sites of lymphoid involvement seems more consistent with the "multicentric" theory [7] of the origin of malignant lymphoma. Others [8] suggest that there is a single site of origin of this disease by citing the long term survival if not actual cure of selected patients with isolated sites of disease, such as in the gastro-intestinal tract, when treated by excisional surgery or x-radiation therapy.[9] Our patients were most often susceptible to a rapid and random rather than slow and orderly progression in the sites of disease.[9] This spread appeared in such an unpredictable manner that it would suggest that all of the lymphoid and reticuloendothelial tissues possessed the potentials of developing the malignant lymphoma. Whatever its origin and spread may be, the general behavior of this illness is most consistent with a systemic disease.[10]

An applicable comparison of survival figures is with the series of Minot and Isaacs [5] reported in 1926. They grouped together all of their patients and did not separate them by histologic classification as we have done. They totaled 238 patients treated with radiation and found an average life expectancy of 2.9 years. This was compared with 163 nonirradiated cases whose average survival was 2.45 years.

1. Lenz, L., Wells, J. and Stout, A. P.: Hodgkin's Disease and Lymphosarcoma; Clinical Therapeutic Radiology. Nelson, New York (1950).
2. Symmers, W. St. C.: Primary Malignant Diseases of the Lymphoreticular System. Cancer, Vol. 2. Butterworth, 1958. London, England.
3. Peters, M. V. and Middlemiss, D. C. H.: Am. J. Roentgenol., 79:114 (1958).
4. Hoster, H. A. and Dratman, M. B.: Cancer Research, 8:1832 (1948).
5. Minot, G. R. and Isaacs, R.: Journal of the American Medical Association, 86:1185 (1926).
6. Hall, H. A. and Olson, K. B.: American Journal of Medicine, 20:392 (1956).
7. Hellweg, C. A.: Surgery, Gynecology and Obstetrics, 84:950 (1947).
8. Jacobson, L. O.: Journal of Chronic Diseases, 6:437 (1957).
9. Peters, M. V.: American Journal of Roentgenology, 63:299 (1950).
10. Cook, J. C., Krabbenhoft, K. L. and Leucuta, T.: American Journal of Roentgenology, Radium Therapy and Nuclear Med., 84:656 (1960).

In duplicating this simple calculation, we totaled the average survival of all of the 136 irradiated cases that we had been able to follow and found a surprising similar figure of 2.9 years. This similarity of treatment result was carried over further in that Minot and Isaacs [5] ended with 7 patients surviving over 10 years; our 6 long-term survival patients are comparable in number. This series is also comparable to another one [1] which reported 10-year follow-up experience in 133 patients receiving x-ray therapy for Hodgkin's disease between 1918 and 1940 and 242 patients with lymphosarcoma similarly treated. Their 5-year survival for the Hodgkin's disease was 19 per cent, compared to ours of 16 per cent. Their 5-year survival for the lymphosarcoma (including the reticulum cell and giant follicular lymphoblastoma) group was 27 per cent, while the corresponding calculation for our series was 21 per cent. These calculations suggest that our series is representative and comparable to those analyzed 10 and 30 years ago; and is generally consistent with other current reviews on lymphosarcoma,[10] reticulum cell sarcoma and giant follicular lymphoblastoma.[11] The major conclusion from these comparisons is the surprising lack of modification of the clinical outlook and prolongation of life over these past 40 years of treatment of the malignant lymphoblastoma. It was apparent to us whether x-radiation is used or not, and whether or not the alkylating agents and adrenal cortical steroids are also added, the ratio of survival was not affected. This has already been mentioned by Craver [12] and by Hall and Olson.[13] Both groups could demonstrate no proof (except for an occasional long-term survival) that x-ray therapy has prolonged the life of patients with any of the lymphomas. Some data [3] have suggested such a prolongation of life. The usefulness of these alkylating chemicals such as HN_2 and TEM lies either in obtaining a rapid relief from the general systemic toxicity that accompanies the widespread involvement with these malignant neoplasms,[8] or when a so-called decongestant effect is desired,[12] as in a superior mediastinal obstructive syndrome or spinal cord pressure syndrome. When a remission was induced with these chemicals, it was most often transient[8] and less complete than the remission usually obtained by a course of x-ray therapy. This has been reported by others.[12]

Steroids were useful in treating the symptoms of the disease unsuitable or unresponsive to other therapy especially in the ambulatory patient. However, we were careful in our observations to look for the untoward side reactions such as the inducing of active peptic ulcer or the aggravation of a pre-existing diabetes mellitus which could confuse and complicate the major therapeutic aim of controlling the malignant lymphoma.

What then is the advantage of therapy with any of these modalities? Is the expense, the physical discomfort or the potential danger ever-present with these powerful therapeutic agents worth the effort? Each of these therapies (especially x-radiation) does offer some relief from the symptoms of these malignant lymphomas. Our patients were always grateful for their remissions for whatever length of time they lasted. Removal of their pains and discomforts, their anorexia and weakness, their cosmetically unsightly nodulations have always been worth the strenuous exertions of the therapy. Moreover, for this short time, they could participate again as a useful and welcome member in their homes and community. This positive result cannot be minimized. Its usefulness and general acceptance has been demonstrated by the ever-enlarging x-ray facilities throughout this country designed to keep pace with the demands for these treatments, for, x-radiation therapy is accepted as the treatment of choice for the malignant lymphomas.

One fact, however, now seems obvious; the

11. Rosenberg, S. L., Diamond H. D. and Craver, L. F.: Annals of Internal Medicine, 53:877 (November, 1960).

12. Craver, F. L.: American Journal of Roentgenology, 76:849 (1956).

13. Hall, H. A. and Olson, K. B.: American Journal of Medicine, 20:393 (1956).

therapies must not endanger the patient. Since we cannot offer a cure for this illness, no matter to what strenuous lengths and intensities we push any of these therapeutic instruments, we must use the greatest discretion when we prescribe them. This is especially important in balancing the indications for the use of the newer cytotoxic agents against the possibility of inflicting irreversible damage to the hematopoietic or other sensitive cellular systems.

SUMMARY

1. A group of 168 cases of malignant lymphoma treated at the Newark Beth Israel Hospital Tumor Clinic from 1930 to 1959 were tabulated and analyzed. Included were 84 cases of Hodgkin's disease, 54 of lymphosarcoma, 22 of giant follicular lymphoblastoma and 8 of reticulum cell sarcoma.

2. There were 98 males and 70 females. Of this total of 168, only four were Negroes. Malignant lymphoma appeared in all age groups, including those over 70; but occurred most frequently between the years 30 to 60.

3. The most common symptoms were of enlarged regional lymph nodes, especially in the cervical chains, which were often tender and painful. Fevers, sweats, anorexia and weight loss, in descending order, were the other common complaints.

4. The involved sites were usually readily located at the time of diagnosis, but these areas increased rapidly in number and in a random fashion with new metastases appearing in other distant lymphoid and reticuloendothelial-containing tissue.

5. Average length of survival was 34 months for Hodgkin's disease, 27 months for reticulum cell sarcoma, 27 months for lymphosarcoma and 55 months for giant follicular lymphoblastoma.

6. Radiation therapy is still the mainstay in the control of malignant lymphoma and repeated courses were required in the majority of patients.

7. Nitrogen mustard chemotherapy and adrenal corticosteroids, though helpful in controlling symptoms, have not increased the survival time in this group of patients as compared to other series reported prior to the use of these medications.

201 Lyons Avenue

The Deep Voice of Pregnancy

In a September 1959 issue of the *Muenchener Medizinische Wochenschrift*, E. Nessel estimates that about one pregnant woman in every five reports her voice deepening as a result of laryngopathia gravidarum. This common feature of the toxemia of pregnancy is caused by vasomotor and secretory disturbances of the upper respiratory mucosa. As a rule the voice returns to normal soon after parturition. In the case reported, however, the change to a manlike voice continued for nine years. The deepening occurred together with enlargement of the larynx in the patient's second pregnancy. A third pregnancy did not affect the condition. There has been some endocrine dysfunction in this woman, though no other symptoms of such a disorder have been found.

Drop-Outs from Nursing

Every year one in 25 girls of college age is attracted to nursing as a profession, according to a recent issue of Patterns of Dis*ease*, published by Parke, Davis and Company (July 1961). However, the casualty rate is high. In 1956, about one in three trainees did not complete her training. Five percent of active nurses leave the working force annually. Marriage is often given as a reason for resignation. Some 60 per cent of active nurses are married.

On why nurses leave their jobs, personal reasons rank as the commonest, accounting for 34 per cent of reasons. Second commonest reason is "other position accepted," accounting for 22 per cent; and third is "moving from city," with 15 per cent.

State Activities • • •

Family Fallout Shelters*

The Union County Civil Defense and Disaster Control, in cooperation with the Union County Medical Society, has just completed a most timely project and the response has been most encouraging. The general public has become increasingly aware of the importance of the fallout shelter. Since Radiation Defense is a section of the Medical and Health Preparedness Division of the Civil Defense organization and in order to place in the hands of the general public as rapidly as possible technical information for the construction of the home fallout shelter, quantities of the booklet entitled "The Family Fallout Shelter" MP-15, issued by the Office of Civil and Defense Mobilization were forwarded to every doctor, dentist and veterinarian in Union County for distribution in their waiting rooms. In this way, we were able to distribute many thousands of the booklets at a most appropriate time.

During the past two years about 100,000 copies have been distributed by the Union County Civil Defense Headquarters. In addition, the *Daily Journal*, with a wide circulation serving Union and Middlesex counties, has been most cooperative in reporting information concerning the fallout shelter.

We have recommended that the county and municipal engineers make a survey of all public buildings to determine their suitability as a fallout shelter.

We would recommend to all the county medical societies and medical civil defense coordinators to duplicate our efforts throughout New Jersey with reference to the Family Fallout Shelter booklet in view of the great response we have had. With construction of many of these shelters the future will look much brighter.

*By J. R. Karel, M.D., Medical Coordinator for Civil Defense, Union County.

Tetanus Immunization

To talk about tetanus immunization seems old hat, but the problem of non-immunization is still with us.

A large section of our population either is not immunized or has exceeded the time limit for booster injections.

This forces us, in some cases, to use tetanus antitoxin which, in spite of negative sensitivity tests, still causes alarming reactions.

The Special Committee on Industrial Health of The Medical Society of New Jersey, at a recent meeting, went on record to re-alert the medical profession of the need for tetanus immunization.

The committee asks that physicians not only emphasize this program in their private practice but also in any of their contacts with industry.

Radio Seminars in Medicine

"Radio Seminars," is a way of reaching physicians with graduate training. It is now in its third year.

With the cooperation of an FM radio station in New Jersey, and a grant-in-aid from Smith Kline and French Laboratories, they are produced by the Pennsylvania Hospital Continuation Education Program, supported by the John A. Hartford Foundation, of New York.

Physicians take part in these programs at "listening posts"—places where doctors listen in groups either in a hospital, medical society headquarters, or in private offices, or individually on private FM receivers.

At the hospitals where there are two-way audio facilities available, doctors gather at the noon hour and listen to the program while they eat a quick lunch. At the conclusion of the formal part of the program, each hospital is given the opportunity of asking questions of the lecturer at the Philadelphia Station WHYY. These questions are received and simultaneously broadcast.

You can hear these programs Tuesdays, Wednesdays and Thursdays over WHYY (90.9 mc.) from Philadelphia. Thursday programs are also broadcast from WFMZ in Allentown, Pa., at 100.7 mc.

Topics follow—

October 17, 18 and 19—Dysfunctional Uterine Bleeding—James D. Garnet, M.D., University of Pennsylvania.

October 24, 25 and 26—Headache—Joseph B. Green, M.D., Pennsylvania Hospital.

October 31, November 1 and 2—Food Allergies, First Year of Life—George Blumstein, M.D., Temple University School of Medicine.

November 7, 8 and 9—Lipemia and Arterial Disease—Peter T. Kuo, M.D., University of Pennsylvania.

November 14, 15 and 16—Errors of Metabolism—George D. Ludwig, M.D., University of Pennsylvania.

November 28, 29 and 30—Use and Abuse of Digitalis—Louis R. Dinon, M.D., University of Pennsylvania.

AMA Clinical Meeting to Study Medical Aspects of American Habits

The personal and group habits of patients in their everyday lives have a profound effect on the health of the individuals. Now a group of Denver physicians, plus a colleague from Wyoming, will present a study of medical aspects of American habits as a highlight of the program of the clinical meeting of the American Medical Association, November 26 to 30 at Denver. This program will include such topics as "The Coffee Break," by E. Chester Ridgway, M.D., Cody, Wyo.; "The Psycho-Stabilizers," by Jack O. Stoffel, M.D.; "Psycho-Sexual Aspects," by Bradford Murphey, M.D.; "The Pet in the House," by Francis T. Candlin, D.V.M.; "Automobile Driving," by Horace E. Campbell, M.D., and "The Cocktail Hour," by Clyde E. Stanfield, M.D.

The Colorado group has been studying the American habits to be covered in the section for some time, and the program is certain to draw wide interest among the profession.

A study of heredity as it relates to human ills will be presented as a feature of the meeting. Geneticists are rapidly advancing fundamental knowledge in this medical field. This new knowledge will be passed on to clinicians for their guidance in practice.

"Genes, Chromosomes and Human Disease" will be the general subject of the section, under chairmanship of Leroy J. Sides, M.D., of Denver.

Suicide will be analyzed in a group of papers that will help the clinician in recognizing symptoms and taking preventive steps among his patients. Topics on this subject will include "Statistics and Public Health Significance," "Causes," and "Prevention."

A paper on "Fact and Fancy Regarding Glasses" will be presented by two Denver ophthalmologists, M. Kaplan and George A. Filmer. Duane D. Lahey, M.D., of Denver, will discuss "Indications for Contact Lenses."

John H. Talbott, M.D., editor of the *Journal of the American Medical Association*, will deliver a paper on "Gout." Space medicine will be reviewed. Much has been learned by the specialists in space medicine that will be of value to the practicing physician in treat-

ing patients who seldom get off the ground. This knowledge will be presented in a section on space medicine at the meeting.

"The Impact of Space Medicine Research on General Medicine" will be discussed by Hubertus Strughold, M.D., research consultant to the Aerospace Medical Center.

Other space medicine topics will include "The Air Force Program in Aerospace Medicine," by Maj. Gen. Oliver K. Niess, Surgeon General of the U. S. Air Force and "Space Radiations: Their Physical Characteristics and Biological Implications," by Col. Gerrit L. Hekhuis, chief of radiobiology, School of Aerospace Medicine.

An interesting series of papers will be presented at special breakfast programs. Topics for these unique sessions include "The Malmstrom Vacuum Extractor in Obstetrics"; "A Pyelogram Clinic"; "The Operation of a Poison Control Center"; "Community Care of Psychiatric Patients vs. Prolonged Institutional Care"; "Dermatology Quiz Session," and "Unusual Diagnostic Problems in Pulmonary Surgery."

Color television programs during the meeting will include "The Art of Psychiatric Interviewing," "Resuscitation of the Newborn," "Total Abdominal Hysterectomy," "Primary Dermatologic Disorders" and "Dermatologic Manifestations of Systemic Disease."

Also scheduled is an outstanding program of medical motion pictures to be screened daily during the sessions.

Open Discussion on Medical-Surgical Plan

195th Annual Meeting

May 13, 1961

The discussion on the Medical-Surgical Plan was convened at 4:55 p.m., Dr. Royal A. Schaaf presiding.

PRESIDENT MCCALL: This is no longer a meeting of the House of Delegates, but will you ladies and gentlemen please take your seats?

I neglected to bone up on my history before this meeting and so I'm not at all sure of just exactly how many years this particular discussion of Medical-Surgical Plan's problems has occurred with participation of the members of the House and certain guests.

Dr. Schaaf, how long has it been?

DR. SCHAAF: I think this is the sixth session.

PRESIDENT MCCALL: I intend now to turn the rostrum over to Dr. Royal Schaaf, who will then, after one introduction here, carry on for the remainder of the session.

Before I allow him to talk to you, I would like to introduce a man many of you know—Duane Minard, recently appointed as President of Blue Cross, succeeding the late Carl Withers.

I have had the privilege during the past year of personal association with Mr. Minard in connection largely with the activities of Blue Shield. I would like to take this opportunity of saying that my opinion through the year is likely to produce a degree of support that I think he can be well proud of if that same support exists in loads of other people. I think he may need the support of those loads of other people, and I'm going to wish him the best for now.

Mr. Minard, would you mind standing? (Applause)

MR. DUANE MINARD: My words, Gentlemen, are simply those of appreciation for the gracious invitation that your president has extended to me to come down and be a listener in the august assembly which is taking place and the important transactions which will occur here in the next week. Similarly, our president, Royal Schaaf, has invited me to come down and again put what talents I have to learning in an obviously complicated field and one which affects all of the people in New Jersey so directly and so all-embracingly.

I'm here without portfolio, Ladies and Gentlemen. While elected to the Blue Cross presidency, it is not effective until Monday, so in a sense I claim immunity.

Thank you very much. (Applause)

PRESIDENT MCCALL: The topic of joint

riders as far as Blue Cross and Blue Shield are concerned will probably be subject to close scrutiny by Reference Committee and House of Delegates action during this particular session. Therefore, I suggest that it would be inappropriate to bring up questions in regard to any joint rider, as far as Blue Cross or Blue Shield are concerned. If you will honor that suggestion, I'm sure the discussion will go along profitably and I hope that you will gain a lot from it. Dr. Royal Schaaf.

(Applause)

DR. ROYAL A. SCHAAF: Good afternoon, Ladies and Gentlemen and welcome to the annual session at which we review the activities of the Medical Service Administration and the Medical-Surgical Plan. I would like to congratulate The Medical Society of New Jersey upon the new President of the Blue Cross Plan. Mr. Minard has been on the Board of Blue Shield for several years. He has contributed greatly to the activities of the Plan, and a little while ago, right after he was elected President of Blue Cross I had a telegram from Dr. Lloyd of Trenton, in which he congratulated me on successfully running a school for Presidents of the Blue Cross Association. Mr. Minard followed Mr. Withers who went to Blue Cross from the Blue Shield Board. We are very proud of Mr. Minard and I'm sure we are all going to give him great support and the collaboration between the two Plans, I am sure, will be greater than it ever has been in the past.

I now present Mrs. Marie Nugent, Administrative Secretary of Medical Service Administration. She has served in that capacity as our only employee for the past eleven years. She has done a wonderful job. As Ed Sullivan says, let's give her a great big hand. (Applause)

Your supplemental report on the Medical-Surgical Plan indicates that we have engaged a new public relations officer who will be operating with the Blue Shield Plan exclusively but will cooperate with Blue Cross when our interests are jointly concerned. It's my pleasure to present Mr. Frank Romaine over here.

(Applause)

Then our public relations man from Blue Cross, who has done a great job for both Plans and is still doing a good job for both Plans—Mr. Jefferson Lyon. Will you take a bow? (Applause)

And then we have Mr. Harold Black, who is President of Black, Little and Company, who conducts our advertising campaign.

(Applause)

On the dais, you know Mr. Durgom and Dr. Alfano and our counsel, Mr. William Vanderbilt. They need no introductions.

Now, let me say a few words about Medical Service Administration before we get on to the Medical-Surgical Plan. It's exactly twenty years since Medical Service Administration was incorporated and Dr. Elton Lance was its first president. He was very effective in the preliminary work that led to the establishment of the Medical Service Administration and he was president until he left to join the military forces in 1942. He was succeeded by Dr. Tom Lewis, who served until 1949 and then I took over the presidency.

Medical Service Administration was incorporated to develop plans for the care of people with low income; but we found that people with low income couldn't pay premiums and therefore we were obliged to abandon the insurance approach for the care of the low income people. We then developed Plan Number Two, which became the Medical-Surgical Plan by separate incorporation.

The Medical Service Administration deserves a great deal of credit for the work that it has accomplished. It was the Medical Service Administration that developed the program of Medical-Surgical Plan. We conducted the Farm Plan of the State of New Jersey as long as that plan was in being. With the prosperity incident to the war, the need for the Farm Plan disappeared. But in 1943, we undertook what became known as the Newark Plan for the care of the medically indigent persons in Newark. That plan continues in operation. It has been highly successful. It has been gratifying to the patients who have the choice of physician. It is gratifying to the city fathers. It is gratifying to the doctors. It is a more economical method of providing medical care for the indigent persons than the previous method of district physicians. It is certainly much more satisfactory when you consider the quality of medical care that is now distributed under the plan.

Since December of 1956 the Medical Service Administration has been conducting the Medicare program for dependents of certain military and other personnel.

We have transmitted funds to physicians in the amount of about $1,400,000 in the years in which we have been operating. This is tremendous service to the doctors in New Jersey and the Administration merits credit for the work that it has done. It has certainly saved a lot of money for the Society. Were it not for the Medical Service Administration it would be necessary for The Medical Society of New Jersey either to conduct the business

itself by developing an office staff to cope with it; or by having a public insurance company do it; or by having the Government itself do it. It has been a very creditable performance and we hope that if and when the time arises when we might have to appeal to the Society for a grant of $5000, as we had for some years in the past, that it will be forthcoming. We are not requesting it at this time.

With that brief summary of the Medical Service Administration, I would like now to talk about the Medical-Surgical Plan.

The annual report deals with the business end of the administration in dollars and cents. It has been a highly successful year as it has in every year in the past. The one thing you note is a decrease in the amount of our reserves which came about because in October of 1958 our premium rates were reduced 5 per cent; and at the same time we made increased payments along the lines that we had agreed to do for the Medical Society. We made good on our pledges. That led to a reduction in our reserves; but fortunately we have succeeded in obtaining from the State Banking Department permission to increase our premium rates by about 15 per cent. We asked for 25, but we were induced to accept the 15 per cent; this we did reluctantly but gratefully because it will enable us to stay solvent. The prime reason for not granting the full request was that the State Banking Department felt that we did not need as high reserves as we presently have.

The premium rate went into effect on contracts becoming payable in the month of May and each month the new contract rate will apply. All of our subscribers have been informed of the new rate.

I am not going to speak at any length about the rider for diagnostic service. That will be discussed in the Reference Committee. But a very difficult and troublesome problem is being satisfactorily resolved. You will find in the papers given to you today an addendum to our supplemental report. This indicates that the State Banking Department has agreed to let us conduct this particular rider and sale.

There have been some changes in the Board. We lost Mr. Withers and I take this opportunity to express our appreciation for the great contribution which he made to the welfare of the Medical-Surgical Plan. He was a very shrewd banker and a shrewd investor and he augmented our return from our investments very substantially—hundreds of thousands of dollars in the several years in which he had charge of our funds—and he made really a great contribution to us.

He has been replaced by Mr. Weidemeyer, Executive Vice-President of the National Newark and Essex Bank in Newark. Mr. Weidemeyer is a very fine investment banker and we are expecting the same type of service from him that Mr. Withers gave us.

At the request of The Medical Society of New Jersey, we have amended our By-Laws to make two additional places on the Board. The membership now will be 23 rather than 21.

We have a great many problems, but with patience and perseverance we will overcome them, and for the most part we have reached a satisfactory conclusion. The most contentious thing which we had was these riders; but they have been, we think, satisfactorily resolved.

I now ask for questions from the floor.

Dr. Dillard: I'd like to ask if it is possible to have this meeting held at a time when the whole Society is here and not just when the delegates are here. This is of interest to the whole Society. It ought to be held at a time when the whole society is present. (Applause)

Dr. Schaaf: We'd be perfectly happy. The larger the audience, the better. Indoctrination of our physicians is a continuing thing. We have a wonderful public relations program. You have received in the mail in the last few days a folder which shows what the Plan is doing in public relations. We are educating the public and we still have to indoctrinate some of our doctors. That is intended to be a pun.

The Medical-Surgical Plan is under serious threat. I don't think that the average person appreciates the implications of Assembly Bill 197 passed by the As embly Monday night. If this becomes law, it will be a very destructive thing. We have to remember that the provision of 51 per cent of doctors practicing in the county was established at the behest of the State Banking Department itself when this Plan was developed and it was established because the Banking Department felt that the subscribers should be guaranteed at least a fair number of participating physicians and we have been able to maintain that participation and exceeded it; now it's about 80 per cent, which is very gratifying.

The proposal to abandon the requirement that the majority of the Board be physicians is dangerous. If lay people get in charge of professional fees, as they would, the fees would be gradually depressed and it would degenerate into what is in effect a clinic type of medical practice. New York State has had this

same problem to contend with and they are not happy about it.

Dr. Donnelly's comments were well made. I think that he did not emphasize one point and that is that it is the right of any professional person to set a fee for his services. Any professional person should object to having people in other professions or so-called lay people setting his fees for him. Governor Meyner himself as a practicing lawyer would have objected mightily had some Board or the Banking Commissioner said that he couldn't charge a certain fee. The crux of the thing is including this provision in A-197, the provision which will give the Banking Commissioner the right to dictate fees. I could foresee the departure of many of our participating physicians from participation in the Plan if it would go into effect. Personally I shouldn't wish to continue if fees were being set arbitrarily by a lay person who has no idea of what the value of the service is or what the competence of the practitioner may be and so on and so on.

But it will take concerted effort. There are 21 senators. The senators can be made to see that if this plan were adopted it would lead to deterioration in the standards of medical care in the state. Anybody who studies it carefully will come to the same conclusion.

QUESTION: Could you briefly refresh our memory as to what the technical and legal relationship is between the Medical-Surgical Plan of New Jersey and The Medical Society of New Jersey.

DR. SCHAAF: Legally there is no connection. The Medical-Surgical Plan of New Jersey and the Medical Service Administration are independent corporations. The Medical-Surgical Plan, being an insurance company, is under the supervision and control of the State Department of Banking and Insurance. That is the legal status. The moral status or the practical status is something else.

Every year the membership of the Board or the nominations for appointment to the Board of Trustees are submitted to this House of Delegates. Up until the present time no recommendation by the Board had been disapproved by this House. Actually if the administration of the Plan was not satisfactory to the majority of the House of Delegates they would not approve our nominations and we could not continue to serve. We would have to serve temporarily until a new group were appointed.

The technic is for the Medical-Surgical Plan to nominate a person for a vacancy. That nomination goes either to the Board of Trustees, if it is between sessions of the House or it comes to the House if we are in session. If the nomination is approved, then at the next meeting of the Board the nominee is formally elected. But legally there is no connection between the Medical-Surgical Plan of New Jersey and The Medical Society of New Jersey. However, I think that everyone knows that as a Board we are acutely aware of the sentiment and the ideas and the proposals and the recommendations and occasionally of the demands of The Medical Society of New Jersey.

QUESTION: If the Medical-Surgical Plan comes before this House of Delegates with a proposed panel of officers and you either accept them *in toto* or reject them *in toto*, then this becomes a rubber stamp. Would not it be a better system to have each man voted on individually rather than as a group?

DR. SCHAAF: It could be. There is no legal reason why it should not be done. It can be done if that's what the House of Delegates want to do.

QUESTION: Is this approval mandatory?

DR. SCHAAF: Not at all. We must have the approval of the Medical Society to elect.

QUESTION: Then if you put in a lot of lay people and the House of Delegates didn't approve it—

DR. SCHAAF: We would have nothing to do with this new setup in A-197. That would be a separate corporation entirely. They want to modify the statute controlling medical service corporations so that the provision of the 51 per cent and approval by a society of 2,000 doctors and a majority of the trustees—they want to rule that out and they would set up a separate corporation. We would have no control over that.

DR. HYMAN OREN: I think I speak for many doctors when I suggest that we review the way the Board of the Plan is elected and perpetuated. A more equitable plan, perhaps, might be to elect Board members by and from among the several county medical societies. Another grievance is that you treat doctors like kindergarten children. You penalize them if they don't participate. Also, why this arbitrary 51 per cent rule? We ought to have 100 per cent participation: but you won't get it by treating doctors as children.

You say we should insist on the right to set our fees. That's what Dr. Schaaf just said. But actually, Dr. Schaaf, I don't have that right now. I have to accept the fee set up by the Plan. Sure you have an income bracket differential. But look at it this way. Is $7500 a lower income range? If so, 95 per cent of

the school teachers in New Jersey are practically indigent.

Previously it was the moral responsibility of every doctor in the community to set for each patient an equitable fee for the services he is going to render. Sure, I get plenty of widows that I operate on. So what? They tell me, well, I have a little insurance policy with the Omaha. I realize you have no other money, I'll accept that. There is no reason why I can't say the same thing with the Medical-Surgical Plan. To my patient I have a right to raise the fee. If she says it will be a little hard—that she needs extra money, I'll charge less. It's perfectly all right with me. I don't object to that at all, because I have the prerogative, the right to say this is what my fee is; and this I think should be reviewed. We should correct this situation.

We should make this a simple contract and encourage putting something in bold print on the face: Please read your contract. The minute people go on as an individual, why aren't they sent a large notice which, in no uncertain terms, will tell them that maternity benefits have now ceased? I have had so many complaints from patients saying that they did not know it didn't cover maternity. How long have they had it? Over a year. Did you read your policy? No. Have you been notified. No. These are the things that are of the utmost importance in public relations.

Years ago only reputable physicians belonged to the Medical-Surgical. Now we don't hear this any more. We are qualified though we don't belong. We should have a forthright type of advertising going on; namely: "Look: this is what we pay towards your fee to help you overcome your catastrophic problem or to assist you through your crisis." Fine. I agree with that 100 per cent. But don't propagandize my patients and everybody else's patients. We pay the whole bill. This fellow may make $40,000 a year. He doesn't know. He thinks the Plan pays his whole bill and, he gives me a hard time afterwards.

I'm giving you some of the criticisms I have heard from many doctors. Take a good look at it and see what is going to be done. For instance, on maternity, allow seven days.

DR. SCHAAF: You are talking about Blue Cross.

DR. OREN: Yes, I know that.

DR. SCHAAF: This is Blue Shield now. Stay off Blue Cross.

DR. OREN: All right. Consider the bill, A-197. Labor is behind it and this is a paradox. Here is Labor asking more wages for their men, at the time they are asking us to take less money. Instead of opposing these people, fighting with them, let us sit down and cooperate with them. Let's face the situation and get the best deal we possibly can instead of saying we are going to stand up for our rights. If we become belligerent, we will get the worst deal we possibly can. We should look at these things realistically and evaluate them and see if we can't get 100 per cent participation of the physicians in the Medical-Surgical Plan of New Jersey by removing all these wounds which have existed and still exist in certain areas.

DR. SCHAAF: Are you a participating physician, doctor?

DR. OREN: No, I am not.

DR. SCHAAF: It is true that we do not pay non-participating physicians directly. That is not a decision of the Board of the Medical-Surgical Plan. That is the decision of this House of Delegates made time and time again. We finally persuaded the State Banking Department to go along with it as a service to the public.

Now, some of your comments are appropriate to Blue Cross, particularly your reference to hospital coverage for maternity. We have no limit on that care. We are going to pay $150 now for a delivery and we pay additional complications of pregnancy. We are doing a tremendous job, and I sensed that you were not a participating physician.

QUESTION: In the event that A-197 becomes law, would that empower the Banking Commissioner to change the fee to the Medical-Surgical Plan?

DR. SCHAAF: No. It would be a separate plan set up with an entirely different arrangement. It would either be arranged like H.I.P. is in New York or like group health insurance is in New York, but it would be a separate, entirely separate corporation with different fees, different benefits.

QUESTION: I understand that at present if a participating member resigns, it takes one year before it becomes effective. I was concerned because if the fees are arbitrarily lowered would that one year period be still in effect?

DR. SCHAAF: The participating physician's agreement requires that a physician maintain his participation for one year from the date that he submits his resignation. The likelihood is that the fees will not be reduced materially in that contract time. It would only be when the new contracts were issued or when the renewal date came up that that change in contract rate would occur and the payments might be reduced; but we have to guarantee that we

will give the full coverage provision to people in the income group during that contract year. We have to do that. The State Banking Department requires it.

QUESTION: Do you think it would be of interest to our group here if there was some expression with relation to multiple insurance coverage?

DR. SCHAAF: I am going to give Mr. Durgom a few minutes to elucidate the question. He can summarize it in a comparatively short time.

QUESTION: There are a number of us who have been disturbed by the question of the Board of Trustees. Last year at the House of Delegates meeting I attempted to make a nomination to the Board of Trustees from the floor of the House. This was ruled out of order. Many doctors feel that we actually do not have any control of Blue Shield; that there has been a perpetuation of the Board of Trustees, as evidenced by the list here of the nominees for the current year for approval; that we have acted as a rubber stamp. I am gratified to see that you have included the possibility of two new members this year. But if we look at the list we see one man in 1959, another nominated in 1960 as new members of the Board and it would be our suggestion that the Board of Trustees be selected in another way, as suggested by one of the delegates earlier; that they be approved by county medical societies.

DR. SCHAAF: The Medical-Surgical Plan of New Jersey is an insurance company. It is big business. This year our income will be $35,000,000. You cannot have a rotating Board of Directors.

I happen to be on the Board of Directors of a fairly large insurance company. Some of the directors have been on that 35 years. And there is continuity of service which makes for safety in the administration of a corporate body that's handling that much money. I think the new members will tell you that they take three or four years before they get the feel of this business. It's a very complicated business.

Now, I can tell you this, that if a member of our Board did not serve well or wasn't able to serve, we would not reappoint him. We have done that once or twice. A number of our men were not renominated because they were inattentive.

I have served on a lot of boards and a lot of committees. I think Mr. Vanderbilt, who is our counsel will bear this out. I have never sat on a board where the attendance and the interest and the dedication is as great as this board is. Remember, nobody gets paid.

Dr. Donnelly spoke of two evenings a month. Well, that's true, but that's only part of it. There are many more evenings and constant telephone calls.

Rotation on the board is not good at all. Any sound businessman or banker or insurance company director will tell you that the stability of an insurance company depends on a continuing board of directors who know what they are doing.

We have appointed a number of people who have been nominated to us; in fact the last two appointees who are filling these vacancies have come from the Board of Trustees of the Medical Society. They didn't emanate from us.

But it would be disastrous if we established a system of rotation where in three years you dropped a man.

DR. ROBERT BRILL: The worry, I think, in the minds of many of us when one has a self-perpetuating board is that this board then becomes a third party selling the medical services of the members of The Medical Society of New Jersey. Your arguments concerning the stability of such a board of trustees is cogent and valid. However, there is a solution which would enable you to have such a board with stability and still have members of The Medical Society of New Jersey able to express some of their desires and perhaps bring to the attention of the board of trustees these board of trustees things which either have not previously been brought up or were brought up in the past when they were not right but under the present situation they might be reconsidered. I would like the Board of Trustees to consider requesting from The Medical Society of New Jersey some kind of a liaison committee, which has representation from not just the President of The Medical Society of New Jersey but from several of its officers and also perhaps from county societies or from specialty groups to get non-voting expressions of opinion which would be helpful for the Board in formulating new policies.

DR. SCHAAF: I'm grateful for the suggestion and our Board is most receptive to suggestions. Every county society has an advisory committee to the Medical-Surgical Plan of New Jersey. We also have a tripartite and we hope that it will be a quadpartite committee. Presently the tripartite has three officers from The Medical Society of New Jersey, three from the Medical-Surgical Plan and three from the Hospital Plan. We hope we will have three from the New Jersey Hospital Association. And whenever there are questions of common concern, those three groups meet. Representation of The Medical Society of New Jer-

sey in that committee is the Chairman of the Board, the President of the Society and the Executive Officer. And you have corresponding officers of the two Plans.

We welcome suggestions, but the fact is that we don't get many recommendations and suggestions and comments and criticisms. We like criticisms because you think you get pretty good after awhile. Unless somebody tells you you are not, you get rather self-sufficient. But there are the mechanisms now in existence that you mentioned. Maybe they aren't utilized enough, but that is not the difficulty with the Plan itself.

Very occasionally (so seldom that I can count them on both hands) a serious dispute arises between a doctor and the Plan about the payment of the fee. We make a practice never to argue with the doctor. We talk it over and if we can't come to an amicable agreement, we refer the problem to the advisory committee of the doctor's county society. In that area the committees have not worked well at all. The members of the county committee don't like to make a recommendation unfavorable to one of its own members. It's a perfectly understandable reaction. I wouldn't want to pass judgment against a fellow member of the Essex County Medical Society. To deal with those problems the Plan asks the medical society to appoint a review committee. There are five full members and five alternate members and they meet. This has been going on only in the last few months. We have turned over eight or ten cases to that committee, and they also passed judgment on them. So far as the Plan is concerned, their judgment is final. If they say: we think this bill is right and you ought to pay it, we will pay it if we can. If they think it is wrong, then *they* have to convince the doctor that he is wrong. But we don't get involved in it at all.

To be fair to the people that we ask to do this work, we have set a fee of $50 a meeting for all ten of them; that is, the regular members and the five alternate members, and we want them to come even if they are not voting members. We want them to be indoctrinated with the problem. Any man who appears at one of those meetings gets his $50, and we think that that is a fair way of asking impartial people to settle different questions for us. It is a good mechanism. If anybody knows a better one, we'd be happy to have it, because this was evolved from experience and difficulty in solving these problems.

Dr. Alexander H. Fishkoff: I'd like to know whether the individual enrollments are open on a yearly basis now or special occasions.

Dr. Schaaf: Individual enrollments are open always. Group enrollments are open only at certain times.

Dr. Fishkoff: If they are open always, why don't we have flyers go out to all the physicians in the state acquainting them with that fact? I personally didn't know about it.

Two years ago this multiple insurance and the third party liability proposal as a rider was passed by the House of Delegates. So far nothing has come of that. I'd like to know why.

Dr. Schaaf: The State Banking Department objected.

Dr. Fishkoff: Why isn't that fact brought to the attention of the House of Delegates so we can do something about it? There simply must be a way of doing something about it. Just making a statement isn't sufficient. I think that a special committee from your group or from the House of Delegates should meet with the Banking Department on that proposal. Many physicians in our county are not members of the Plan and many a time with men doing general surgery and traumatic surgery, multiple insurances and third-party liability problems come up. Originally, this Plan that we have now was an all-inclusive service plan for low wage income groups. It's gone far and beyond that, which is a wonderful thing in itself. Look at third-party liability where a doctor treats a person who has another insurance like the multiple type of insurance; or he may have insurance through an automobile insurance, for example, that pays medical expenses; or he may have a liability insurance; or he may have a claim settled through a court proceeding wherein the Medical-Surgical Plan does not provide for full payment. That was the purpose of this rider being suggested two years ago.

If there is no other way than taking *no* as an answer, then a committee from the House of Delegates should go to the Banking and Insurance and find a way of handling this problem.

Dr. Schaaf: I think that Dr. Alfano has a good deal of material on this question and I'm going to ask him to pick up these points.

Dr. Alfano: We had the Dumont Commission hearing this past year and during the hearing we were asked as to what we felt might be needed changes in the law. We brought this question up. Would they consider an amendment to the law to conform with the sentiments of the State Medical So-

ciety on multiple insurance and third-party liability? The Dumont Commission still has not issued its report; but they have taken this into consideration so that maybe (when their report goes to the Legislature for recommendations) it may contain something that might help this situation. But the State Banking Department has objected.

Dr. Summey: Dr. Schaaf, I haven't been here before, but to hear most of the comments one would think that most of the doctors in the state didn't like the Plan, and I don't think that's the case. You know, you have heard the story perhaps about in the better years in the British Parliament when they didn't have Russia and such things on their minds, Parliament used to argue about fox hunting, and there was the Irishman who got up one day and said: "Contrary to the usual custom in this house, I'm getting up and speaking in favor of the fox." And so today I'd like to speak in favor of the trustees. I think they have done a pretty good job. And I would almost leave it go at that except I would like to say that the members of the Medical Society who are not affiliated with the Medical-Surgical Plan ought to look at themselves and wonder if they are not thriving on the rest of us who are. They don't want the Plan to fold up, but if the rest of us get out it will fold up. I think they ought to have that in mind when they aren't participating physicians.

Also, a study ought to be made to show the labor unions and the government and perhaps the politicians whether the people who have their bills paid by the Medical-Surgical Plan are satisfied. I'd like to see the public relations people go out and make a study of consecutive payments and see whether the people like it. If that could be done we'd get a great deal of support from the public, which some people say we don't have, and we must have with the couple million subscribers.

Dr. Schaaf: Thank you very much for the roses, doctor. We generally get brickbats. (Applause)

And now, Mr. Durgom.

Mr. J. Albert Durgom: You are most gracious, as you are each year when I have the opportunity to come here. It is stimulating to have this opportunity as a lay person to bring to you some of the progress and also some of the problems which we all, in partnership, need to understand in going forward with the voluntary health movement.

Last year the Essex County Medical Society, among other medical societies, was considering major medical coverage for its membership. This is a field which we believe in. Blue Cross and Blue Shield concurs. If there is a catastrophic type of illness beyond the concept of the economics of the run of the mill among the subscribers in all walks of life buying this coverage, then it is proper that there be a program to alleviate the economic burden on one who is so unfortunately stricken. However, the whole voluntary health movement is in jeopardy over the growth of major medical to the astronomical heights of overlapping benefit payments. The overlapping portion goes to the patient as money in pocket rather than proper equity of distribution of those monies to those who are rendering the services. So my theme is boom or boomerang. It's a boom to the one who receives the money in pocket; it's a boomerang among those others who have not been able to collect because they were not so stricken, fortunately, but must pay higher premiums to carry the load as a class. And it's a boomerang to the voluntary health movement because the commercial insurance companies are faced right now with the dilemma of how far this which they have created has gone out of hand in the competitive field of the business among themselves. Out of 132 million across the country with basic coverage, two out of three already of the whole population of America, there are actually one out of seven already with overlapping coverage in terms of dollars. The voluntary movement—Blue Cross and Blue Shield—has paid the price tag for health benefits of two billions of dollars last year and major medical has already risen to the height of nearly a half a billion dollars of money in pocket to the patient beyond what Blue Cross and Blue Shield have paid for what is known as full inclusive service. This is a serious situation.

It's a question of how soon the voluntary health movement—Blue Cross and Blue Shield—find it possible to supplement its basic coverage and keep it under control where major medical benefits will begin after Blue Cross and Blue Shield have ended. Those with an income level will get inclusive service and those who go to semi-private will get inclusive service through the respective Blue Shield and Blue Cross Plans. Those who might have their employer buy for them major medical places those people in a different economic category than that measured solely by their income from work. This is the cold fact that we need to face.

As a result, we took a count from among the Essex County medical group of the claims

that were over $500 to measure the program of major medical which would reimburse over $500, notwithstanding that Blue Cross may have covered the entire bill of $2,000; and we found that Blue Cross had lost over $10,000 last year on the basic coverage. Thus, the medical group, if it bought the major medical, would have gained over $20,000 in pocket. This is the inequity. This is the theme of the problem that I am trying to approach.

In talking with a number of insurance company officials within the past several months, it is admitted by them that this was not intended to overlap originally; but in fact had just developed to that score by the practices of some casualty insurance companies.

We have advocated in industry to those enrolled under Blue Cross and Blue Shield that *if they buy dual coverage we will have no recourse except to terminate the group.* The responsibility of trusteeship on the part of those administering the program to protect the economics of the distribution of health care because the average person on the street must pay for some gain of another person who just paid another extra premium in order to get back a dollar for a quarter that he put in. And of course, we are getting down to the problem of inequity to all who are affected.

Then that brings us up to another problem. Of the aged, already 150,000 of the 500,000 in New Jersey are being covered by Blue Shield and Blue Cross; or across the country, 16 million aged; 50 per cent of whom are now already being covered by the voluntary health movement. If the voluntary health movement prices itself out of the market, then there is no result except that of Government moving in. I speak of major medical, my attack is constructive. The voluntary health enterprise including commercial insurance as well as the Blue Cross and Blue Shield Plans should reexamine the distribution of health care in order that, in a partnership manner of preserving the equity that rightfully belongs at the voluntary level, none of us must later confess that we could not regulate ourselves and therefore expose ourselves to regulation by the Government.

The solution is simple. You cannot prorate service benefits of Blue Shield and Blue Cross because they are agreed upon payments by the contracting parties; namely, hospitals and doctors. But the insurance companies can and perhaps maybe by a directive be prevented from paying benefits for that part already covered by a basic contract already purchased by the insured. This might well come, and if it should come it certainly ought to come in the voluntary manner. So, as a result of this regulation made known to industry, our leading companies today who have major medical have demanded from the insurance companies that they quote a premium only for benefit payments beyond those services covered by Blue Cross and Blue Shield; and that is what we have today enforced among the industries in New Jersey. And for the others of you who would like to have both, we see no alternative but to adhere to our fundamental responsibility of keeping health care at the lowest possible cost and yet taking care of the nine out of ten so adequately without endeavoring to go over the horizon to take care of the other one who for gainful reasons (not of his own volition) it's just that human behavior hasn't changed; if the carrier is willing to give away two dollars for a quarter, or whatever the proportion may be, then naturally it's not dishonest on the part of the policyholder.

The medical profession should give a very close look to the distribution of health care from within its own mind, from within its own interest because they, too, can radiate the same interest and electrify and stimulate more of this growth of major medical which in its overlapping method of coverage may destroy the whole voluntary movement.

Thank you very much. (Applause)

DR. SCHAAF: Thank you very much, Mr. Durgom.

(The meeting was adjourned at 5:55 p.m.)

Obituaries

DR. SAMUEL G. BERKOW

On the last day of August, Dr. Samuel G. Berkow, president of the New Jersey Obstetrical Society, died while visiting in Copenhagen, Denmark. Born in Europe in 1899, he came to this country in childhood, and in 1922 earned his M.D. at Bellevue. After interning in Long Island City, he took a residency in obstetrics in New York. He devoted his full professional time to obstetrics and gynecology and was a founder of the State Society in that specialty. Director of obstetrics at the Perth Amboy General Hospital, he was the author of a well known text book on sterility. Dr. Berkow was a diplomate in obstetrics and gynecology, and contributed many articles to the medical literature. At one time he did original research on the treatment of burns, and received recognition from military and Civil Defense officials for this. Dr. Berkow was active in the affairs of the Middlesex County Medical Society.

DR. BURT W. BOTBYL

Dr. Burt W. Botbyl, a former Patersonian, died at his home in Los Angeles on August 14 at the age of 72. He retired from practice in 1953, after having served the people of Passaic County for 40 years. Born in Paterson, he received his M.D. in 1914 at Bellevue. He was affiliated with St. Joseph's Hospital in Paterson, and was a Fellow of the American College of Surgeons. During his years in New Jersey, Dr. Botbyl was active in the affairs of our Passaic County Medical Society, and in civic and community affairs in northern New Jersey.

DR. JACOB M. DAVIS

Known as the dean of medicine in South Jersey, Dr. Jacob M. Davis died on August 2 at the age of 88. He was described in the Burlington Press as "one of our county's most illustrious citizens." Born in Camden, he received his medical degree at Hahnemann Medical College in 1899. After interning at the West Jersey Hospital in Camden, he came to Burlington County in 1900 and has served the people of South Jersey ever since. He was a general practitioner, particularly interested in obstetrics and pediatrics. During his professional career, he had delivered more than 3,000 babies. He was school physician in the town of Burlington for 30 years. Dr. Davis served as president of the Burlington County Medical Society and was active in many civic organizations.

DR. GEORGE W. HORRE

Death came on August 31 to Dr. George W. Horre. Dr. Horre, born in Elizabeth in 1894, was graduated in the class of 1921 from the Medical School of Long Island University. Shortly thereafter, he entered the Navy and served in the Navy Medical Corps for several years. Later on he became a member of the Medical Reserve Corps of the Army.

Dr. Horre entered general practice in Elizabeth in 1923 and then increasingly limited his practice to surgery. He served the Elizabeth General Hospital in all grades and eventually became an attending surgeon there. He was also a past president of the Clinical Society of the Elizabeth General Hospital and served as County Physician for many years. He was a Fellow of the American College of Surgeons and was active both in the Union County Medical Society and the New Jersey Society of Surgeons.

DR. ALEXANDER POVALSKI

While vacationing in Casablanca, Morocco, Dr. Alexander Povalski died on September 1. Born in 1898, he was graduated in 1923 from the medical school of the University of Maryland. A general practitioner, he was interested and skilled in anesthesiology, and was the attending anesthesiologist at the St. Francis Hospital in Jersey City. A Fellow of the International College of Surgeons, Dr. Povalski was also certified in anesthesiology. He was active in the affairs of the Hudson County Medical Society. Dr. Povalski was a pioneer in the field of spinal anesthesia.

DR. HAROLD W. SMITH

Dr. Harold Walling Smith died on August 17 at the Orange Hospital Center which he had long served as an attending and later as a consulting orthopedist. Dr. Smith was born in 1896 and received his medical degree at the University of Michigan in 1920. A prominent orthopedic surgeon, he was one of the early Diplomates of the American Board of Surgery. He was a F.A.C.S. and was a consulting orthopedic surgeon at the Essex County Sanitorium in Verona and the Morristown Memorial Hospital. He served some time as president of the Medical Staff of the New Jersey Orthopedic Society. Dr. Smith was also a consultant to the Veterans Administration.

Announcements

Pathologists Meet in Atlantic City

October 27 and 28 are the dates for the session of the N. J. Society of Pathologists, meeting jointly with the College of American Pathologists at the Haddon Hall in Atlantic City. Friday morning's seminar is on abnormal chromosomes; the afternoon meeting is on steroid metabolism. On Saturday there will be a slide seminar on pediatric pathology. You are invited.

A Cardiology Day in New Jersey

The Somerset County Chapter of the American Academy of General Practice and the Somerset County Heart Association are sponsoring a full day on "Modern Cardiology." The day is Thursday, November 16, and the place is the Far Hills Inn in Somerville. The opening paper, scheduled for 10 a.m. is on circulatory physiology. The second talk is on cardiac pharmacology. Then comes a luncheon at which there will be discussion of the emotional aspects of heart disease. The afternoon includes papers at 2, 3 and 4 p.m.—the first one on cardiogenic pain; the second on cardiac surgery. The 4 p.m. presentation is a panel discussion of heart failure. Category I credit is allowed by AAGP. For details write to Dr. John F. Dixon, Jr., at the Kate Macy Ladd Hospital, Far Hills, N. J.

Cosmetology Conference

Cosmetic problems in general practice will be discussed November 8 in Dallas, Texas, at the convention of the Southern Medical Association. Topics include "Skin Protection in the Household"; Cutaneous Cleansing"; "Care of the Nails" and "Dermatitis Due to Cosmetics." This is an AMA-sponsored seminar. For details, write to Committee on Cosmetics, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The Internist's Role in Surgery

The American College of Physicians offers an intensive course in the internist's role in surgery. Given during the week of November 6 at the Mayo Clinic in Minnesota, registration is limited. Tuition fee is $80 except to members of the American College of Physicians who may enroll for a $60 fee. For more details, write to American College of Physicians at 4202 Pine Street, Philadelphia 4, Penna.

Conference on Chromosomes

You are invited to attend a meeting of the Middle Eastern Region of the College of American Pathologists on Friday and Saturday, October 27 and 28, 1961 at Haddon Hall, Atlantic City. The Friday session beginning at 8:30 a.m. will be devoted to "Abnormal Human Chromosomes" moderated by Dr. Alexander G. Bearn of the Rockefeller Institute.

At the afternoon session Dr. Felix Wroblewski of the Memorial Sloan Cancer Center will explain the "Whys and Wherefores of Isoenzymes." Dr. S. Brandt Rose of Chestnut Hill Hospital, Philadelphia, Pennsylvania, will present "Fact and Fancy in Medical Bacteriology" and Dr. James H. Leatham, Director of the Bureau of Biological Research of Rutgers University will discuss "Steroid Metabolism in Health and Disease."

Colonel Joe M. Blumberg, M.C., Deputy Director of the Armed Forces Institute of Pathology will be guest speaker at a banquet at 7:30 p.m. and will give an illustrated lecture on "Pathology in the U.S.S.R."

Saturday morning beginning at 9:00 a.m. will be devoted to a slide seminar on "Pediatric Pathology" moderated by Dr. Benjamin H. Landing, Director of Laboratories at the Children's Hospital in Cincinnati.

Book Reviews

Handbook of Surgery. Edited by John L. Wilson, M.D. and Joseph J. McDonald, M.D. Los Altos, California, 1960. Lange Medical Publications. Pp. 646. ($4.00)

Because of the swift march of medicine, books are often obsolete before they are a year old. Yet one hesitates to discard an expensive volume. The solution would seem to be to issue an inexpensive soft-cover medical book and revise it every two years. This is exactly what Lange has done in its now famous medical series. A surgeon or general practitioner, for example, can own a text like this, never more than 1½ years old, at a cost of $2 a year.

This book includes 19 chapters, running the gamut from postoperative care to neurosurgery, from anesthesiology to plastic surgery. One appendix is a tabulation of all major drugs, giving dosage, complications and use. The inside back cover illustrates the technic of mouth-to-mouth insufflation. There is a table of normal blood values, numerous conversion tables, and material on emergencies. The illustrations are simple and clear. In all, this is as good a four dollars' worth as you can get these days.

VICTOR HUBERMAN, M.D.

Adrenergic Mechanisms. Edited by J. R. Vane, M.D., G. E. Wolstenholme, M.D. and Maeve O'Connor. Boston, 1960. Little, Brown. Pp. 632. ($12.50).

Here are the proceedings of The Ciba Foundation Symposium on Adrenergic Mechanisms held in London in March 1960. Papers by 80 authors are included.

The book will be of interest to the pharmacologist, research chemist, anatomist and internist. The papers begin with the steps in the formation of the adrenergic transmitters and their biosynthesis from catechol amines. Then comes the development of the chromaffin cells and the storage of amines in these cells.

A section deals with the adrenergic neurone and the release of the sympathetic transmitter into the venous blood by nerve stimulation. Certain drugs block this action. Bretylium and guanethedine (Imelin) are discussed as to their effect in lowering blood pressure. The action is believed to be due to adrenergic neurone blocking action similar to sympathectomy. Continuous administration of Bretylium is followed by a gradual depletion of the catechol amines in the adrenergic nerve structures and peripheral organs. The most common side effects produced by these drugs, such as nausea, stuffy nose, parotid gland tenderness, weakness and diarrhea, are discussed as to cause and frequency. The blood pressure lowering is effective in both essential and renal hypertension.

There is considerable discussion on the biophysical changes produced by amines on normal tissues and on depolarized preparations of smooth muscle. On skeletal muscles adrenaline can have a vasodilating or vasoconstricting effect depending on its concentration.

The clinical effects of amine oxide inhibitors such as Marsilid® and Marplan® are evaluated. It is postulated that the discrepancies in results are due to the heterogenicity of disease and the heterogenicity of response to drugs in general. The first effect of this type of drug is to increase the drive and initiative of the patient, then follows the antidepressive effect on the mood.

The symposium contains new and interesting material and is a welcome contribution to the field of adrenal gland chemistry and physiology.

GRACE T. NEWMAN, M.D.

Letters to My Son. By Wendell J. S. Kreig, Ph.D. Box 9, Evanston, Illinois, 1960. Brain Books. Pp. 85. ($3.00)

This little book offers the distilled wisdom of a scientist whose academic career has been spent in teaching and research at medical schools. Now Professor of Anatomy at Northwestern University Medical School, the author is known to many physicians through his 1942 textbook *Functional Neuroanatomy.*

In a series of twelve letters, written in a Chesterfieldian style, Dr. Kreig addresses his "Son"—ostensibly an undergraduate college student interested in a combined career in medical pedagogy and research. A sane guide and gentle critic, "Father" is at times cynical, philosophical and realistic in reviewing the goals, advantages and disadvantages of the academic life. His words about the narrow mental horizons of some medical students and teachers are particularly interesting: "When you are lecturing to medical students, never stray from the subject matter of the course you are hired to teach. The students don't want it; they will pay no attention to it, and they will

come to dislike you for doing it. If you imagine that you are the apostle of culture, the harbinger of the higher viewpoint, and that you should give them the fruits of your broader education, suppress it . . . The medical student doesn't want any more culture; he doesn't want any philosophy; he wants only medicine, and this seems enough to monopolize his attention . . . These strictures extend to the faculty, and I am ashamed to say it. Keep free of frills, and don't expect to discuss extracurricular events such as art, travel, literature, women or hobbies with any but the rare proved kindred spirit."

These original comments, and many others like them, comprise the *credo* of a distinguished scholar whose valuable and thought-provoking ideas are well worth reading.

FRED B. ROGERS, M.D.

Sliced Reconstruction of Cerebral Sections. By W. J. S. Krieg, Ph.D., Evanston, Illinois, 1960. Brain Books. Pp. 26. Paper. ($1.00)

Here is a cross section atlas of the human cerebrum in the form of 13 sections from the frontal pole to the occipital. Fibers are shown on the right half and inner structures and nuclei on the left half. The text is crowded into the margins around the drawings so that the total picture is one of a helter-skelter confusion of words and drawings. Each page seems cramped, and the uniform black-grey-white design makes it hard to distinguish the parts. It is withal a painstaking and scholarly work and a close study—if one has the eyesight and patience—will be rewarded with a fuller understanding of that most remarkable of organs: the human cerebral cortex.

HERBERT BOEHM, M.D.

The Parenchyma of Law. By D. W. Louisell, LL.B. and Harold Williams, M.D. Rochester, N. Y., 1960. Professional Medical Publications. Pp. 517. ($12.45)

In spite of its coy title, this is an excellent and —in some respects—unique book. The title derives from the fact that this text proposes to explain to physicians the tissue of law ("parenchyma"). There are many books on medical jurisprudence which discuss the concept of malpractice or the legal rights of the physician. There are many texts on forensic medicine which describe rigor mortis or the Marsh test. This book tells the intelligent physician-reader just how and why law is what it is. The authors defend malpractice litigations, for example, as "proper instruments of social policy" and tell us why. They defend the doctrine of *res ipsa loquitur* and the collection of large contingent fees by attorneys. The jury system is defended as is the hearsay rule. They explain—and very cogently —law's apparently obsessional concern with procedure and due process. They describe the anatomy of a trial, and deglamorize the Hollywood version. They tell what an "appeal" means and why.

The book looks backwards to the historical roots of law, and forward to possible reformation and reformulations. The text is highly readable, and every physician who has thought that the law was foolish, red-tape-bound or near-sighted owes it to his brother profession to read a book like this. This is more than the advocacy of advocacy, however. It is meaty, factual, useful and thought-stimulating. What more can you ask?

HENRY A. DAVIDSON, M.D.

Virus Meningo-Encephalitis: Ciba Foundation Study Group No. 7. Edited by G. E. Wolstenholme, M.D. and Margaret P. Cameron, M.A. Boston, 1960. Little, Brown and Company. Pp. 120.

This extremely technical book is designed for an esoteric reading audience. It covers recent developments in virologic study, including Echo viruses, Frater viruses, Coxsackie, and so on. Clinical and laboratory signs of some viral diseases are discussed. This reviewer was more impressed with their similarities rather than the insignificant differences. Epidemiology, virologic diagnoses and specific antibodies, as well as prophylaxis and prevention are given some attention.

However, as summarized, "the clinicians and the virologists still seem to be some distance apart." This is recommended as thought-provoking only—rather than specifically informative—and is recommended for those with especial interest in virology.

DAVID J. FLICKER, M.D.

Proceedings of the Johannesburg Pneumoconiosis Conference of 1959. Edited by A. J. Orenstein, M.D. Boston, 1960. Little, Brown and Company. ($22.50)

This volume is a fitting successor in the series of symposia on the pneumoconioses more familiarly known to us in the compendia of the Saranac and McIntyre Conferences of this hemisphere. It will become a standard reference and study work in this field for many years.

The editor, Dr. A. J. Orenstein (Director of the Pneumoconiosis Research unit of the South Afri-

can Council for Scientific and Industrial Research) has chosen well among the various subspecialties of medicine, as well as in the engineering and social fields, to present an authoritative and comprehensive work on our knowledge, and gaps in our knowledge, of this protean problem. For this reviewer the extensive section dealing with function testing of the lungs and its direct applicability to the equitable and scientific determination of disability, particularly in its legal sense, proved particularly interesting.

To those with other foci of interest the book will also prove illuminating. The chapters on the technic and value of large lung section and fume fixation of the lungs are of value in all fields of acute and chronic lung disease. The papers dealing with instrumentation and with experimental physiology and pathology are guideposts to future investigators as well as monuments to the present workers in these subjects.

We are indebted to the participants in this conference (held in 1959 at the University of Witwaterstrand in South Africa) for advancing particularly the work of British, European, and South African authorities in a problem where they have had such tremendous and challenging experience.

THOMAS J. ORMSBY, M.D.

Essential Hypertension—An International Symposium. Edited by K. D. Bock and P. T. Cottier. Berlin, 1960. Springer Verlag. Pp. 392. (No price given)

Forty specialists from 12 countries convened in Berne in 1960 for a Ciba-sponsored symposium on essential hypertension. The proceedings are now available. They are well worth reading by physicians interested in this worldwide vascular disorder. The participants from the United States included Drs. L. K. Dahl, A. Grollman, S. W. Hoobler, I. H. Page, A. J. Plummer and H. A. Schroeder, to mention a few.

Dr. Page presents his "mosaic" theory of hypertension in the first paper. This is followed by considerations of the inheritability of hypertension, sodium metabolism, cortico-adrenal function, renal contributions and aldeosteronism in the etiology of the disease. Benign and malignant hypertension are discussed separately and finally there is a critical review of therapy, including the latest drugs, bretylium and guanethedine.

No aspect of hypertension has been omitted; the discussions are scientific in approach and critical in nature. This is not a subtle attempt at commercial promotion but an honest effort on the part of Ciba to evaluate scientifically the West's knowledge of high blood pressure. For this Ciba is to be commended. The presentations are detailed and supported by appropriate graphs and charts. This book is heartily recommended to serious students of hypertension.

ROWLAND D. GOODMAN, 2ND, M.D.

Clinical Obstetrics and Gynecology (3): New York, 1960. Hoeber (Quarterly). ($18.00 per year)

This fine series of subject reviews has chosen for its present issue the ambitious combination of Symposia, "Fetal Distress and Physiology" and "Endocrinology." All who deal with the pregnant patient will appreciate the clarification of ideas.

Discussions of the effects of maternal pre-diabetes and irradiation on the uterine passage are timely. Warning is given to all practitioners of their duty to avoid "routine" pelvimetry; to avoid fluoroscopy when roentgenograms will suffice; to avoid diagnostic I-131 in pregnancy; and generally shun radiation in an early pregnancy.

The monograph on "Resuscitation of the Newborn" is useful for anyone concerned with immediate neonatal care.

Robert Greenblatt, guest editor for endocrinology, has concisely integrated this specialty with obstetrics and gynecology. Discussion of the newer synthetic pituitary substances is especially valuable.

Zondek, discussing placental insufficiency, shows that where daily output fell below 1000 micrograms, irreversible placental dysfunction had occurred and the fetus was dead. Perhaps serial evaluations of the hormone will prove to be a valuable indicator in this tragic accident of pregnancy.

The discussion of "Hormonal Control of Lactation" includes criteria of control proposed by Dodek. Many technics can meet these criteria considering the small number of patients who complain of discomfort for as long as 24 hours.

Kistner's monograph on the newer progestational agents is very thorough and answers clearly many questions in our minds and the minds of our patients. Specific dosage schedules are outlined.

EUGENE J. SLOWINSKI, M.D.

Epidemiology and the Control of Communicable Diseases. By Fred B. Rogers, M.D., M.P.H. Baltimore, 1961. The Waverly Press. Pp. 77 printed and 77 blank pages. ($5.00)

Intended primarily as a teaching guide, this little book is also a valuable and compact refresher course for practitioners. It covers immunization procedures, the major infectious diseases themselves, and modern concepts of epidemiology. The material is based on Dr. Rogers' lectures at Temple University, and the text developed out of mimeographed notes used as a basis for his lectures. Consequently, the contents were hammered out in actual teaching experience and are pedagogically as well as clinically sound. Alternate pages are blank so that teacher and student can insert their own additional notes. Statements are all well supported by experience or by citations and the book as a whole is a valuable *vade mecum* for clinicians, medical students, and for those who teach the subject at any level.

ULYSSES M. FRANK, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

OCTOBER, 1961 • VOL. XXXIV, No. 8

RECURRENT ASIAN INFLUENZA IN AN INDUSTRIAL POPULATION

Vaccination is the only way to protect workers against influenza, which can severely handicap an industrial group during an epidemic. Less absenteeism was found among vaccinated employees than among those not vaccinated in the study reported.

An epidemic of influenza may di able a significant number of workers in an industrial plant and seriously curtail its operation. At present, vaccination offers the only means of offsetting these consequences.

In the winter of 1960, an outbreak of Asian influenza recurred in an industrial population which had been affected by the 1957-58 epidemic. Since the employees of the plant were subjects of an acute respiratory disease study which encompassed both epidemics, an opportunity was provided for the derivation of clinical, laboratory, and epidemiologic information on Asian influenza.

PROCEDURE

From July, 1957, through the spring of 1960, data on acute respiratory illnesses were gathered from employees of a large oil refinery and petrochemical plant located in Baton Rouge, La. The plant has an average population of approximately 6,200 employees residing in Baton Rouge or nearby communities. The workers' age range was 20 to 65 years, the average being 46. Females constituted less than 5 per cent of the employees and were excluded from the study. Approximately 29 per cent of the male workers were salaried, 43 per cent were maintenance, and 28 per cent were production wage earners.

Historical and clinical information on all respiratory illnesses in 1,000 of these employees was collected. Standard criteria for the clinical diagnosis of influenza included: fever above 100.4°F., prominent malaise or muscular aches, and associated upper respiratory symptoms. An interview between a plant physician and each patient served to corroborate and classify the information in retrospect.

Garglings were obtained for laboratory studies; serologic determinations were done, and antibody was titrated by hemagglutination-inhibition.

VACCINATION

Standard influenza vaccine containing inactivated influenza viruses was obtained from commercial sources in September of each year. Vaccine was offered to employees each fall and winter of the three-year period. In the 1957-58 period, 65 per cent of the workers received a single injection of monovalent Asian influenza vaccine and 34 per cent received a second injection six weeks after the first. The following year 13 per cent of the workers received a single injection of polyvalent influenza vaccine and 30 per cent received two injections. In October, 1959, a single injection of polyvalent influenza vaccine was given subcu-

Neill K. Weaver, M.D.; John G. Lione, M.D.; and William J. Mogabdab, M.D., *Annals of Internal Medicine,* May, 1961.

taneously to 32 per cent of employees. Information regarding the vaccine was coded, thus physicians in recording clinical observations did not know the vaccine status of an individual.

Six hundred cases of typical influenza from the 1960 outbreak were matched with 600 individuals free of significant respiratory disease during the epidemic period with respect to age, service, and job assignment.

ATTACK RATES

Relatively high attack rates (above 14 per 1,000 per month) were maintained from September, 1957, through February, 1958. The over-all case rate for the period was 186 per 1,000. From September, 1958, through March, 1959, only 21 cases of influenza-like illnesses were recorded. Such illnesses were rarely observed in workers during the fall of 1959, but in January, 1960, a sharp outbreak occurred, with a peak of 78 cases per 1,000 employees in February. The over-all attack rate during the third period was 109 per 1,000, virtually all cases occurring during an eight-week period from mid-January to mid-March.

Although patients observed during the influenza epidemics exhibited a variety of disease patterns, a picture considered characteristic of "clinical influenza" was readily recognized: an illness of abrupt onset with fever, chills, respiratory tract involvement, and striking constitutional symptoms of headache, muscular aches, and malaise.

Sickness absenteeism of the plant workers was strictly accounted for, and the accuracy of medical department tabulations was checked against payroll figures.

Employees vaccinated prior to each epidemic experienced fewer cases of influenza and lower disability absenteeism than unvaccinated workers. In 1957-58, the influenza attack rate was 313 in unvaccinated and 123 in vaccinated workers, a reduction of 60 per cent. In the 1960 epidemic, the corresponding rates were 114 and 93, a reduction of 20 per cent. Over-all absenteeism due to acute respiratory disease was lower in the vaccinated group by 45 per cent in 1957-58, and by 30 per cent in 1960, while reductions in absences attributed to influenza were 65 per cent and 27 per cent, respectively.

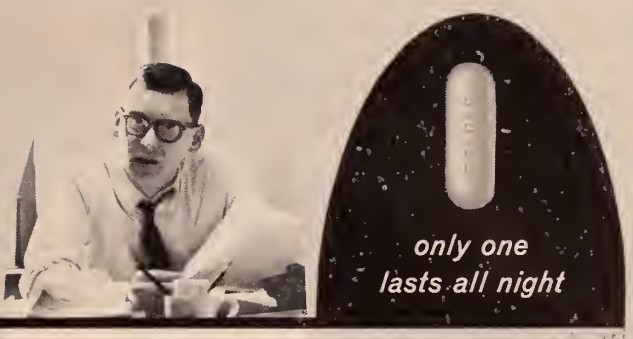
FURTHER STUDY NEEDED

The clinical observations suggest that immunity may have been declining four months after vaccine injection. This interpretation is supported by failure of the statistical analysis to demonstrate any evidence of vaccine protection being carried over from one year to the next. There would seem to be need for further study regarding the optimal dose and route, and time of administration of polyvalent influenza vaccine. It is possible that a regimen of two 0.5 ml. doses (250 CCA units each) spaced more widely apart (September and December) might afford equal or better protection with fewer reactions than the vaccine schedule conventionally recommended.

Analysis of the case of influenza that occurred in 1960 revealed no evidence of immunity due to a previous episode of the disease or to vaccination unless the latter had been administered in the epidemic year. It seems less likely that this will recur a third time, at least in such proportions, since antibody levels appear to be increasing progressively.

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1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

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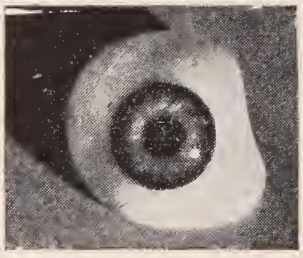
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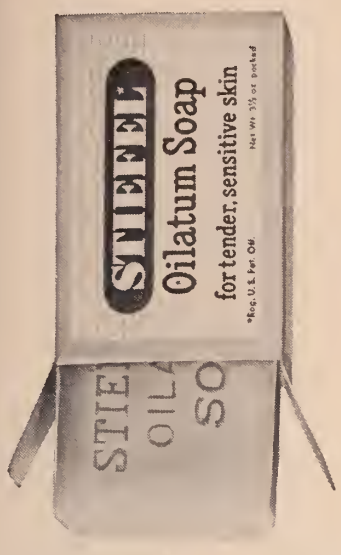
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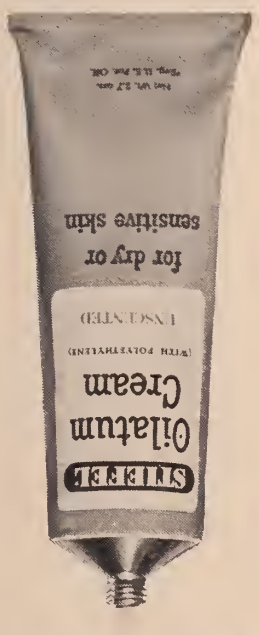
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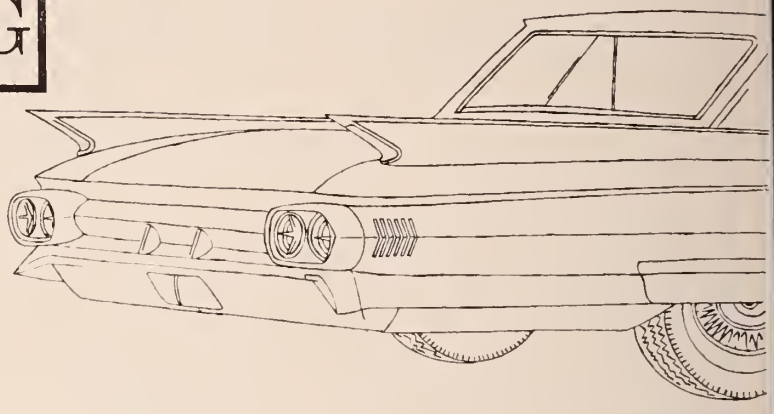
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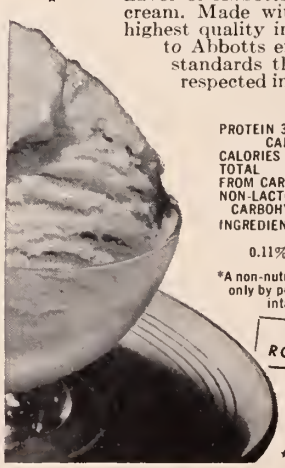
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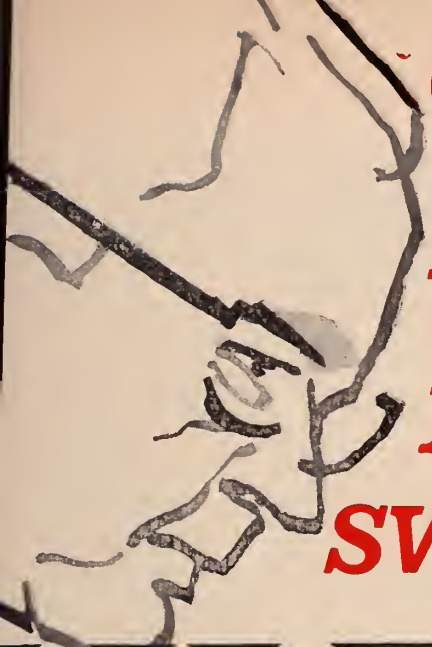
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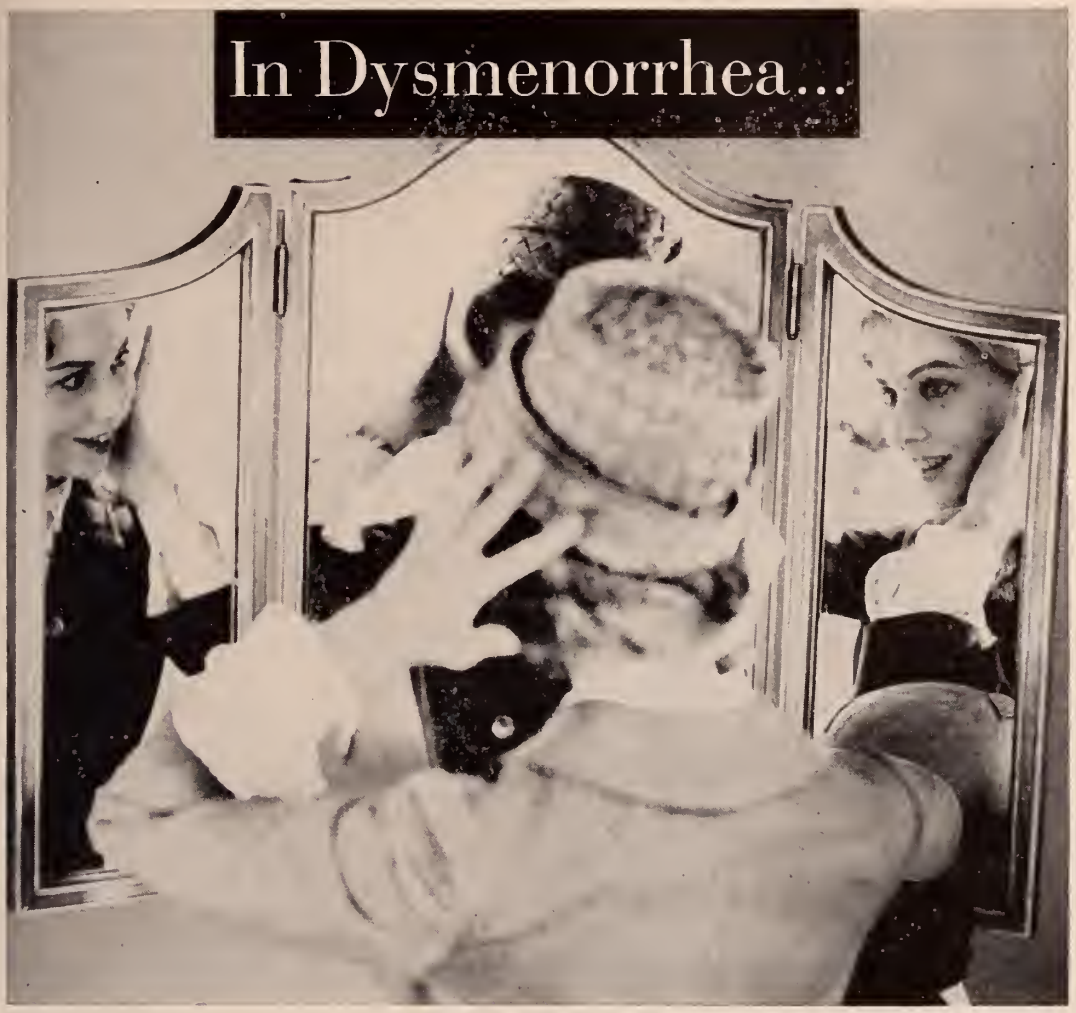
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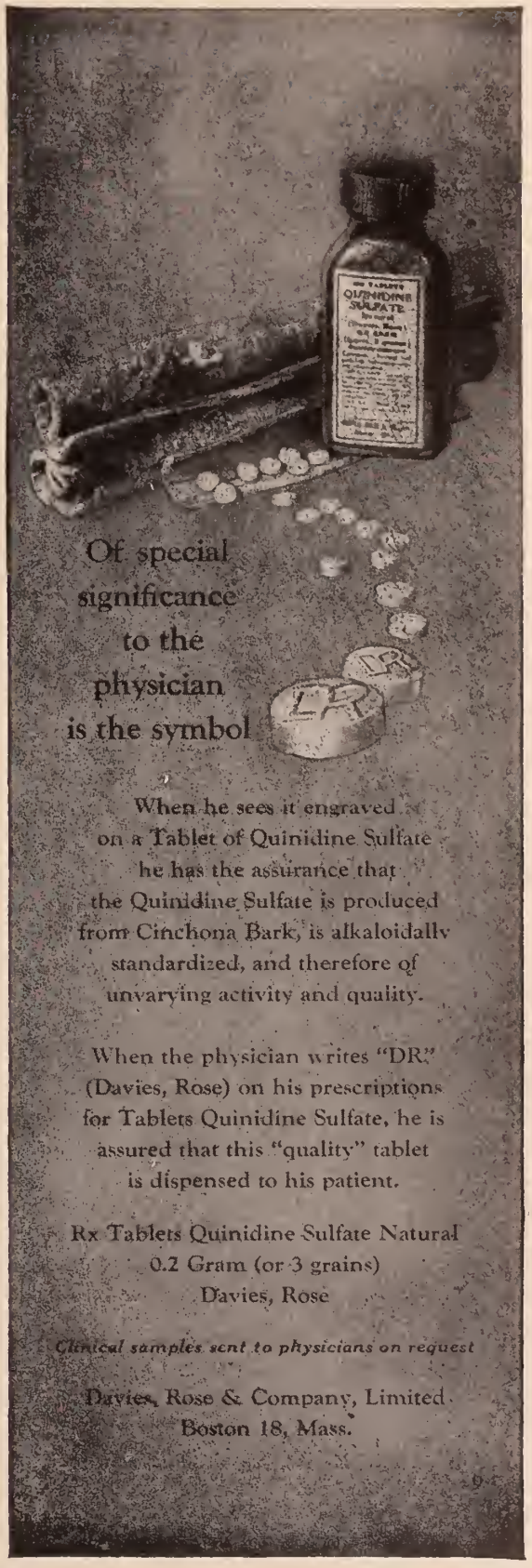
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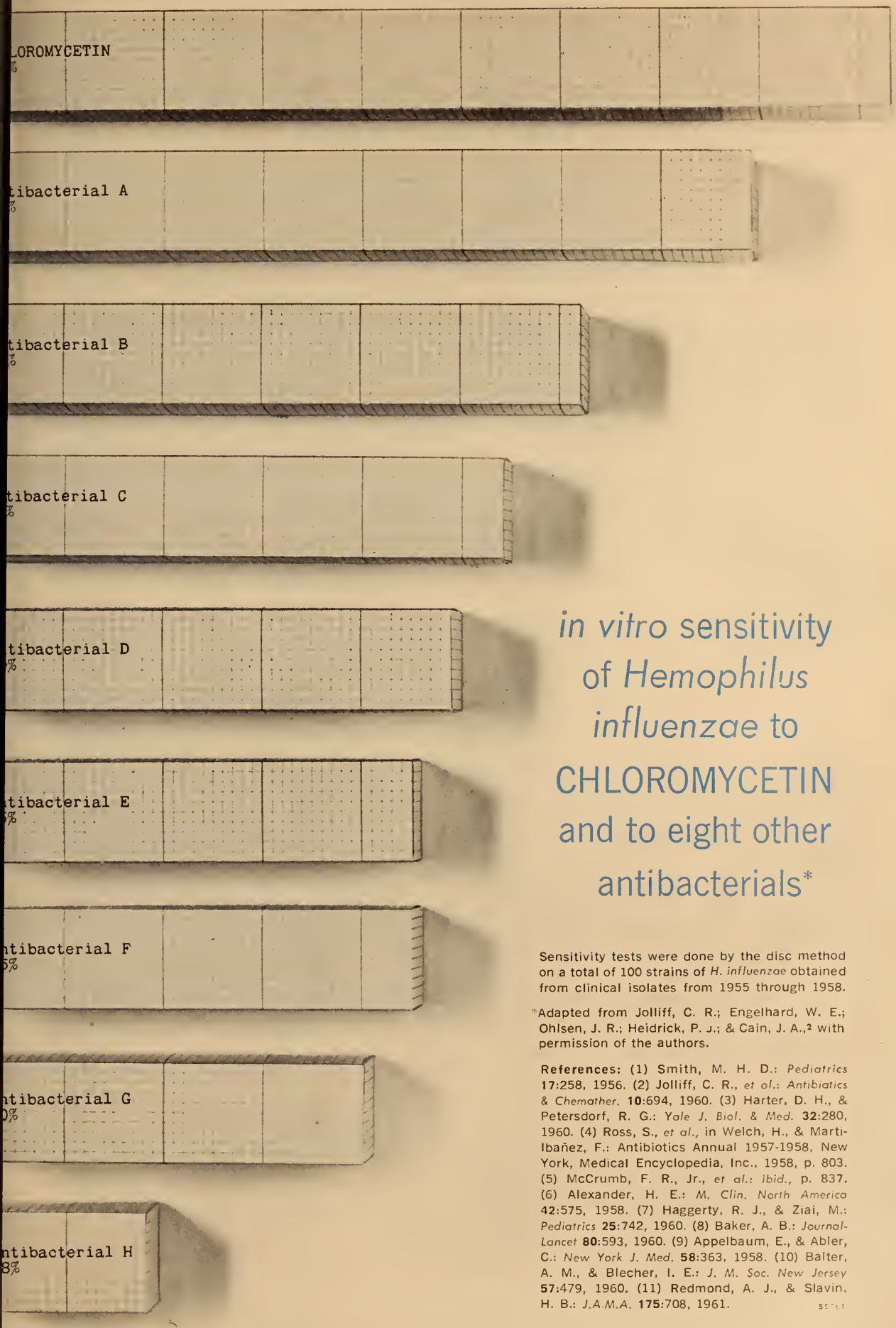
CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

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*Adapted from Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J.; & Cain, J. A.,[2] with permission of the authors.

References: (1) Smith, M. H. D.: *Pediatrics* **17**:258, 1956. (2) Jolliff, C. R., *et al.*: *Antibiotics & Chemather.* **10**:694, 1960. (3) Harter, D. H., & Petersdorf, R. G.: *Yale J. Biol. & Med.* **32**:280, 1960. (4) Ross, S., *et al.*, in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (5) McCrumb, F. R., Jr., *et al.*: *ibid.*, p. 837. (6) Alexander, H. E.: *M. Clin. North America* **42**:575, 1958. (7) Haggerty, R. J., & Ziai, M.: *Pediatrics* **25**:742, 1960. (8) Baker, A. B.: *Journal-Lancet* **80**:593, 1960. (9) Appelbaum, E., & Abler, C.: *New York J. Med.* **58**:363, 1958. (10) Balter, A. M., & Blecher, I. E.: *J. M. Soc. New Jersey* **57**:479, 1960. (11) Redmond, A. J., & Slavin, H. B.: *J.A.M.A.* **175**:708, 1961.

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Second Class Postage Paid at Orange, N. J.

VOL. 58, No. 11 NOVEMBER, 1961 Subscriptions, $3.00 per year
Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., **et al.**: Diabetes 7:398, 1958.

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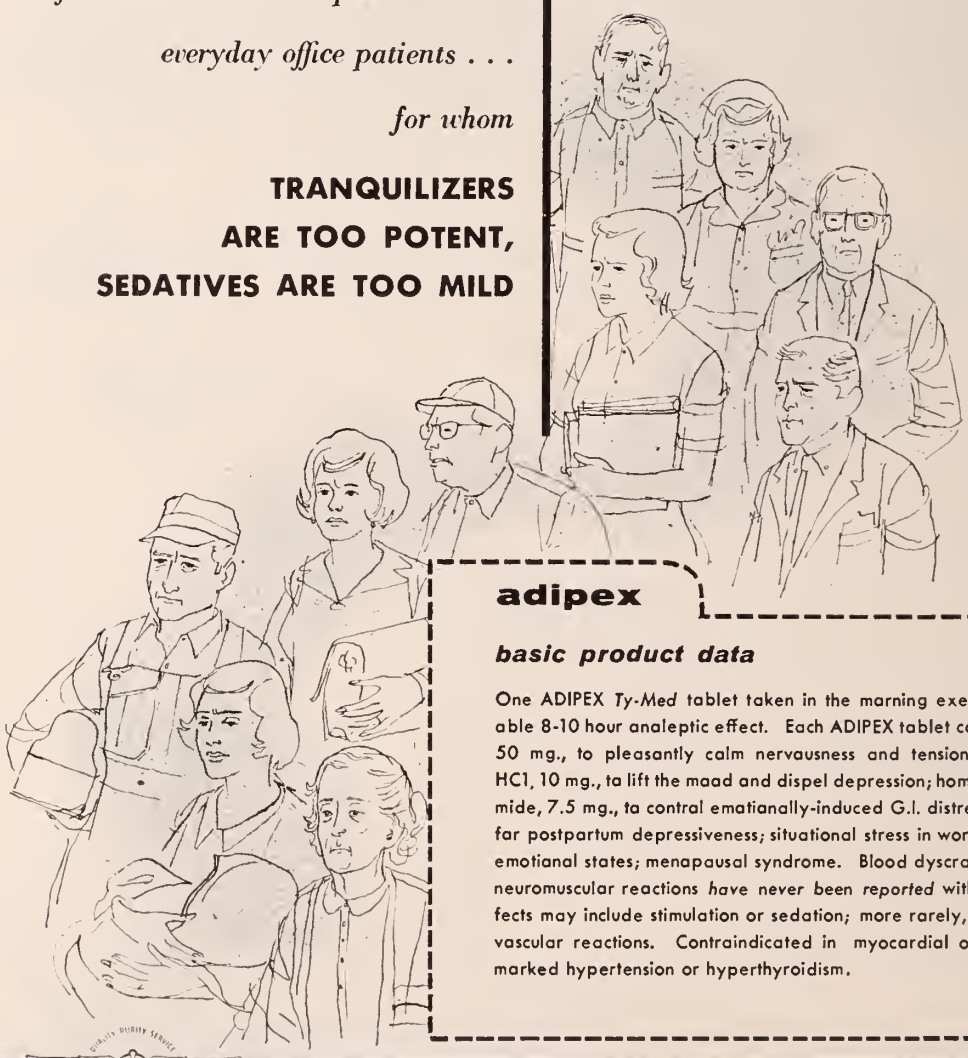
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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

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arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264.

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan, G. G.: Diseases of Metabolism 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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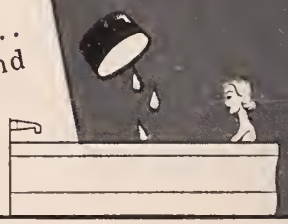
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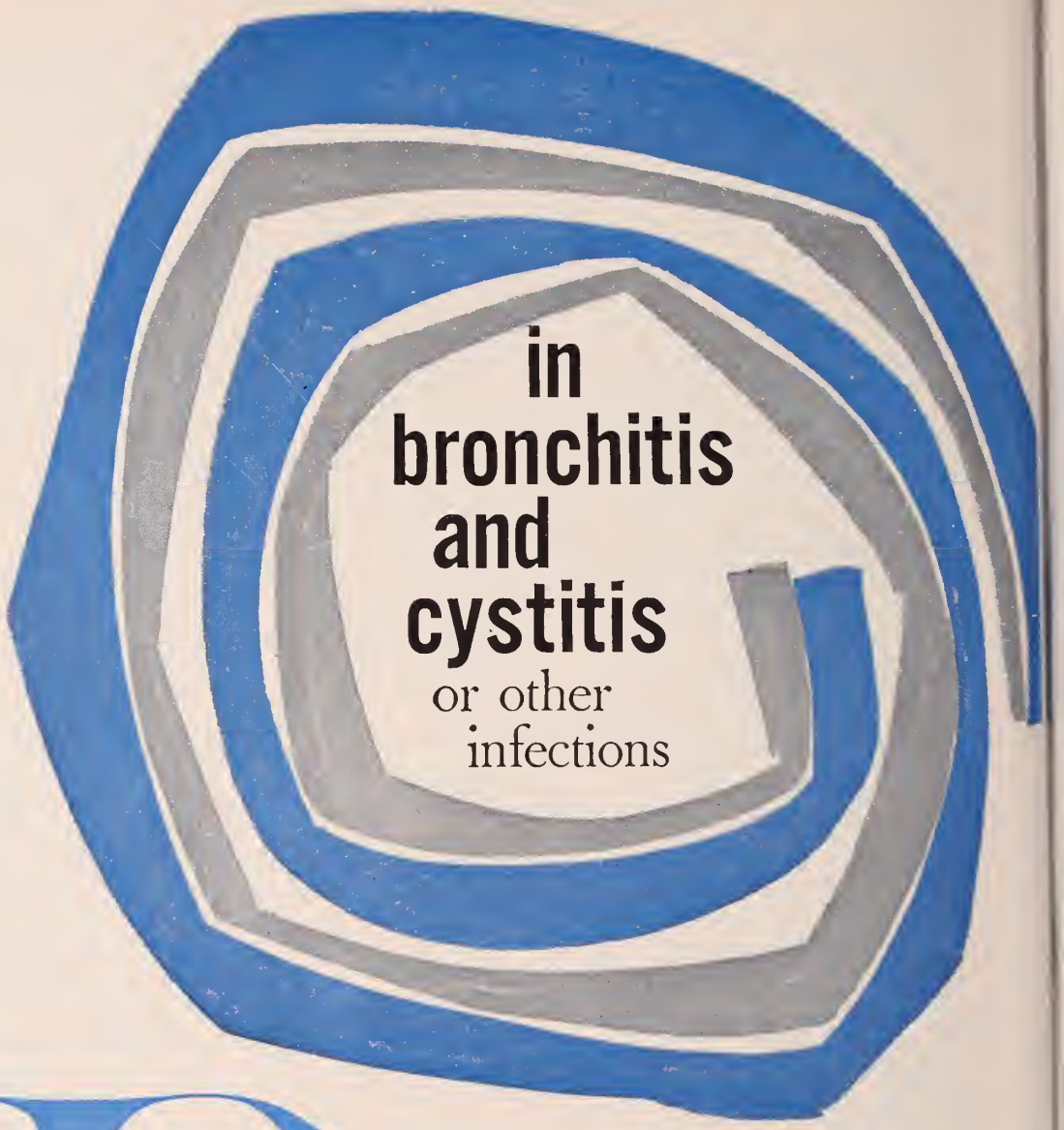
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"flu" than a simple cold, but an antibiotic is not indicated... prescribe NEW WIN-CODIN* Tablets

New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

Codeine phosphate 15 mg.—to relieve local and generalized pain and control dry cough

Neo-Synephrine® 10 mg.—to shrink nasal membranes and open sinus ostia

Acetylsalicyclic acid 300 mg. (5 grains)—to reduce fever and relieve aching

Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

Winthrop LABORATORIES
New York 18, N. Y.

*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

LOGICAL NEW DERMATOLOGICAL HELPS

solve the mystery of Acne Therapy

Brāsivol has a gentle abrasive action that attacks the acne lesion simply and directly. It maintains the mild desquamation so essential to the successful acne regime. Helps open plugged pores, reduce pustules and blackheads, control oiliness. Helps minimize postacne scars. The patient simply applies Brāsivol abrasive cleanser 2 or 3 times daily, and rinses. Ritual helps relieve urge to squeeze pimples. Cooperation is enhanced because results are readily seen and felt. Safety and success are supported in over 10 years of clinical studies on thousands of acne cases. Brāsivol (pat. pend.) contains precisely sized abrasive particles (fused aluminum oxide) and hexachlorophene 1%, in a detergent and drying base. Compatible with other therapeutic measures.

Write for starter samples and literature

STIEFEL®

LOGICAL DERMATOLOGICALS—since 1847

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Oak Hill, New York

CANADIAN REPRESENTATIVE:
WINLEY-MORRIS CO., LTD., Montreal 29, Quebec



Brāsivol Fine *Brāsivol Medium* *Brāsivol Rough*

Brāsivol is supplied in 3 abrasive grades, permitting gradual intensification of abrasive action as the acne improves. Also, Brāsivol Base (abrasive free) now available for acute inflammatory cases.

Jars of Brāsivol Base 5 oz.; Brāsivol Fine 5¾ oz.; Brāsivol Medium 6¼ oz.; Brāsivol Rough 7 oz.

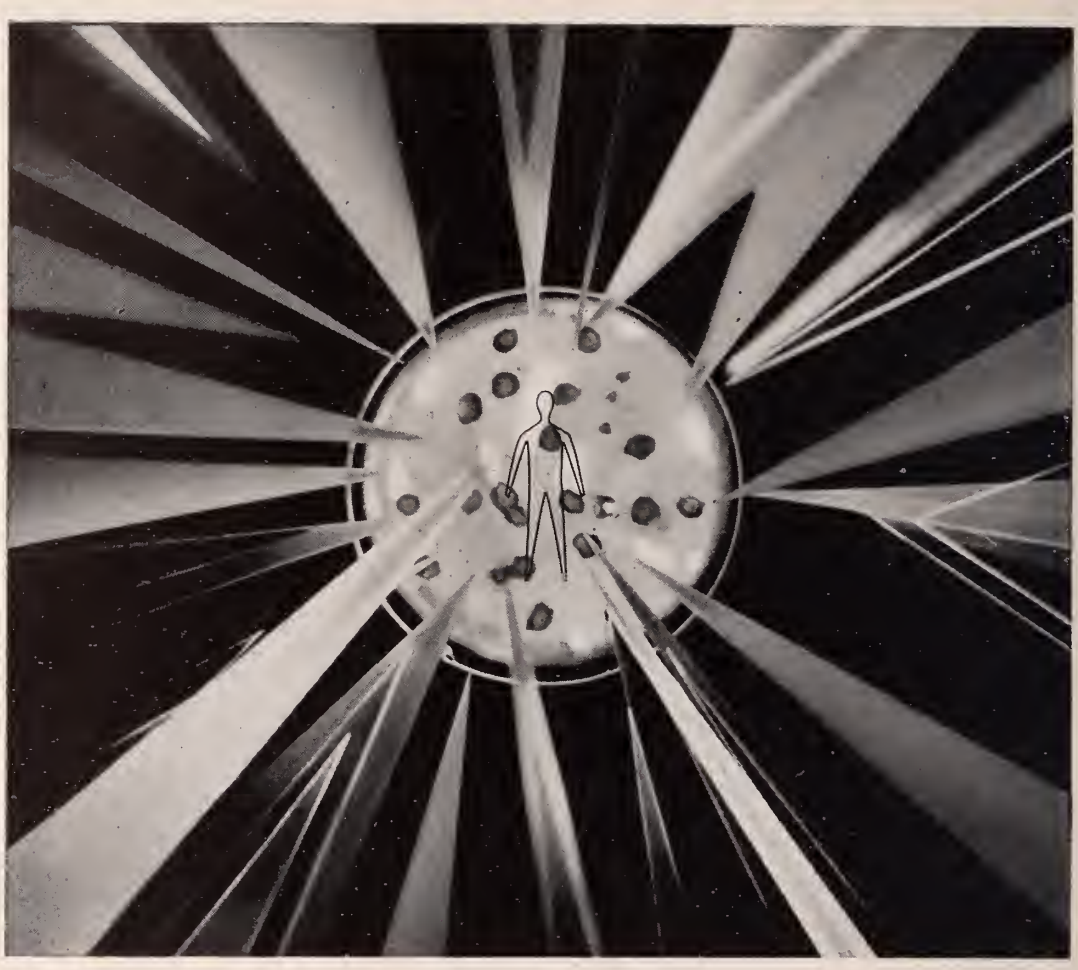
Brāsivol®

ABRASION THERAPY FOR ACNE

in certain other countries Brāsivol is available as DENCO·BRAS™

REFERENCES:
SAPERSTEIN, R. B.: Treatment of Acne with Long Term Continuous Abrasion. A.M.A. Archives of Derm. 81: 601, April 1960.
REES, R. B ; BENNETT, J. H.; GREENLEE, M. R.: Newer Drug Treatment in Dermatology, Cal. Med., 91:1, July 1959.
SULZBERGER, M. B. & WITTEN, V. H.: The Management of Acne Today. Med. Clinics of No. America, 43:3, May 1959.

REFER TO PDR



Why do we say Mysteclin-F is decisive in infection?

because... it contains phosphate-potentiated tetracycline
for prompt, dependable broad spectrum antibacterial action.

because... it contains Fungizone, the antifungal antibiotic,
to prevent monilial overgrowth in the gastrointestinal tract.

Mysteclin-F resolves many respiratory, genitourinary and gastrointestinal infections—as well as such other conditions as cellulitis, bacterial endocarditis, furunculosis, otitis media, peritonitis, and septicemia. It combats a truly wide range of pathogenic organisms: gram-positive and gram-negative bacteria, spirochetes, rickettsias, viruses of the psittacosis-lymphogranuloma-trachoma group.

Available as: Mysteclin-F Capsules (250 mg./50 mg.) Mysteclin-F Half Strength Capsules (125 mg./25 mg.) Mysteclin-F for Syrup (125 mg./25 mg. per 5 cc.) Mysteclin-F for Aqueous Drops (100 mg./20 mg. per cc.)
'Mysteclin'®, 'Sumycin'® and 'Fungizone'® are Squibb trademarks.

Mysteclin-F

Squibb Phosphate-Potentiated Tetracycline (SUMYCIN) *plus* Amphotericin B (FUNGIZONE)

For full information, see your Squibb Product Reference or Product Brief.

SQUIBB *Squibb Quality— the Priceless Ingredient*

A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

DQ-2

As the greatest dental benefits of Sodium Fluoride are derived during infancy and early childhood:

PEDIATRIC VITAMINS
PLUS SODIUM FLUORIDE

provide
proper
nutritional
support
plus
prophylaxis
against
future
dental
caries



FUNDAMENTAL VITAMINS PLUS SODIUM FLUORIDE

Funda-Vite® (F)

PEDIATRIC DROPS

Each 0.6 ml. provides, 400 U.S.P. units vitamin D, 30 mg. vitamin C and 0.5 mg. fluorine (as sodium fluoride). *Available in 30 ml. and 50 ml. bottles with calibrated droppers.*

MULTIPLE VITAMINS PLUS SODIUM FLUORIDE

Quanti-Vite™ (F)

PEDIATRIC DROPS

Each 0.6 ml. provides, 3,000 U.S.P. units vitamin A, 400 U.S.P. units vitamin D, 60 mg. vitamin C, 1 mg. vitamin B_1, 1.2 mg. vitamin B_2, 1 mg. vitamin B_6, 10 mg. niacinamide and 0.5 mg. fluorine (as sodium fluoride). *Available in 50 ml. bottles with calibrated droppers.*

* Daily administrations of Funda-Vite(F) or Quanti-Vite(F) should be consistent and continuous if substantial dental benefits are to be anticipated.

AVAILABLE ON PRESCRIPTION ONLY
CONTRAINDICATED IN COMMUNITIES WITH FLUORIDATED DRINKING WATER.

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SAMPLES AND LITERATURE — Write Medical Department
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PIONEERS IN PEDIATRIC VITAMIN-FLUORIDE SUPPLEMENTS

Increasingly...
the
trend is to

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

confirmed dependability in otitis media is just one reason why





*New evidence** demonstrates the effectiveness of Terramycin in *otitis media* . . . another reason for the trend to Terramycin.

In a series of 41 cases of otitis media, Terramycin not only "was often successful where other antibiotics had failed," but also showed that "it is extremely well tolerated"; oral dosage for infants was 250 to 375 mg. daily, for children, 500 mg. to 1 Gm. In many instances, oral therapy was preceded by intramuscular injection of Terramycin.

The authors concluded that "there is good reason to consider it [Terramycin] one of the most effective agents for treatment of infection of the upper respiratory tract."

These findings confirm the continuing vitality and broad-spectrum dependability of Terramycin, as reported through more than a decade of extensive clinical use.



In brief

The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

More detailed professional information available on request.

another reason why the trend is to Terramycin—*versatility of dosage form:*

TERRAMYCIN Capsules—
250 mg. and 125 mg. per capsule—for convenient initial or maintenance therapy in adults and older children

TERRAMYCIN Intramuscular Solution—
50 mg./cc. in 10 cc. vials; 100 mg. and 250 mg. in 2 cc. ampules—preconstituted, ready to use where intramuscular therapy is indicated

Terramycin®

OXYTETRACYCLINE WITH GLUCOSAMINE

SYRUP PEDIATRIC DROPS

125 mg. per tsp. and 5 mg. per drop (100 mg./cc.), respectively

deliciously fruit-flavored aqueous dosage forms—conveniently preconstituted

Science for the world's well-being® Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.

*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

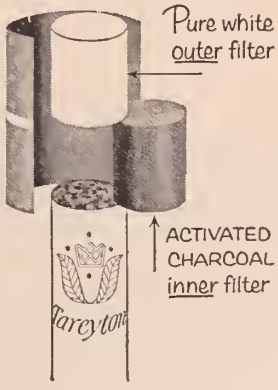
Tareyton delivers the flavor...



Here's one filter cigarette that's really different!

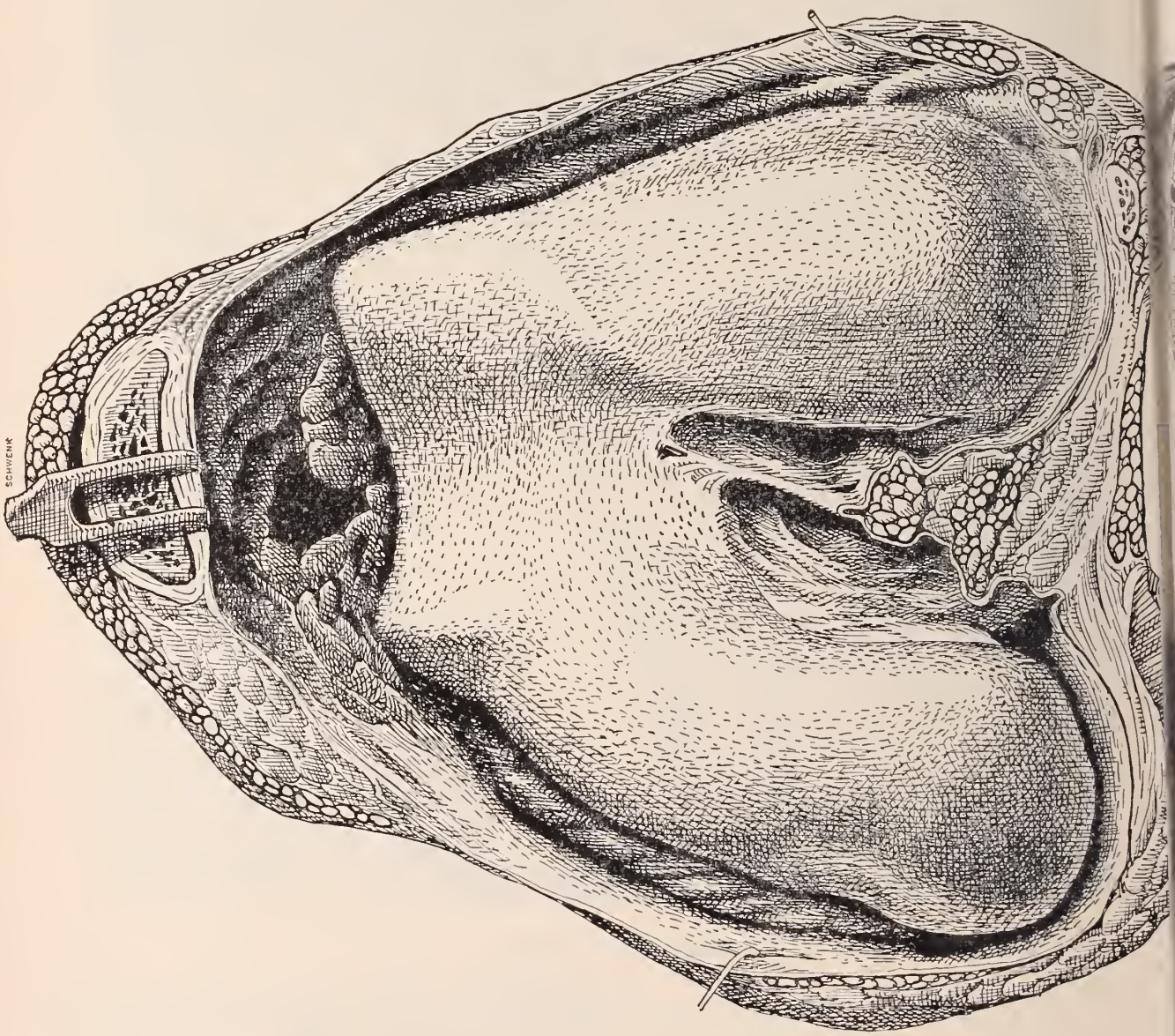
The difference is this: Tareyton's Dual Filter gives you a unique *inner* filter of ACTIVATED CHARCOAL, definitely proved to make the taste of a cigarette mild and smooth. It works together with a pure white *outer* filter—to balance the flavor elements in the smoke.

Tareyton delivers—and you enjoy—the best taste of the best tobaccos.



DUAL FILTER **Tareyton**

Product of The American Tobacco Company — "Tobacco is our middle name" © A T Co.



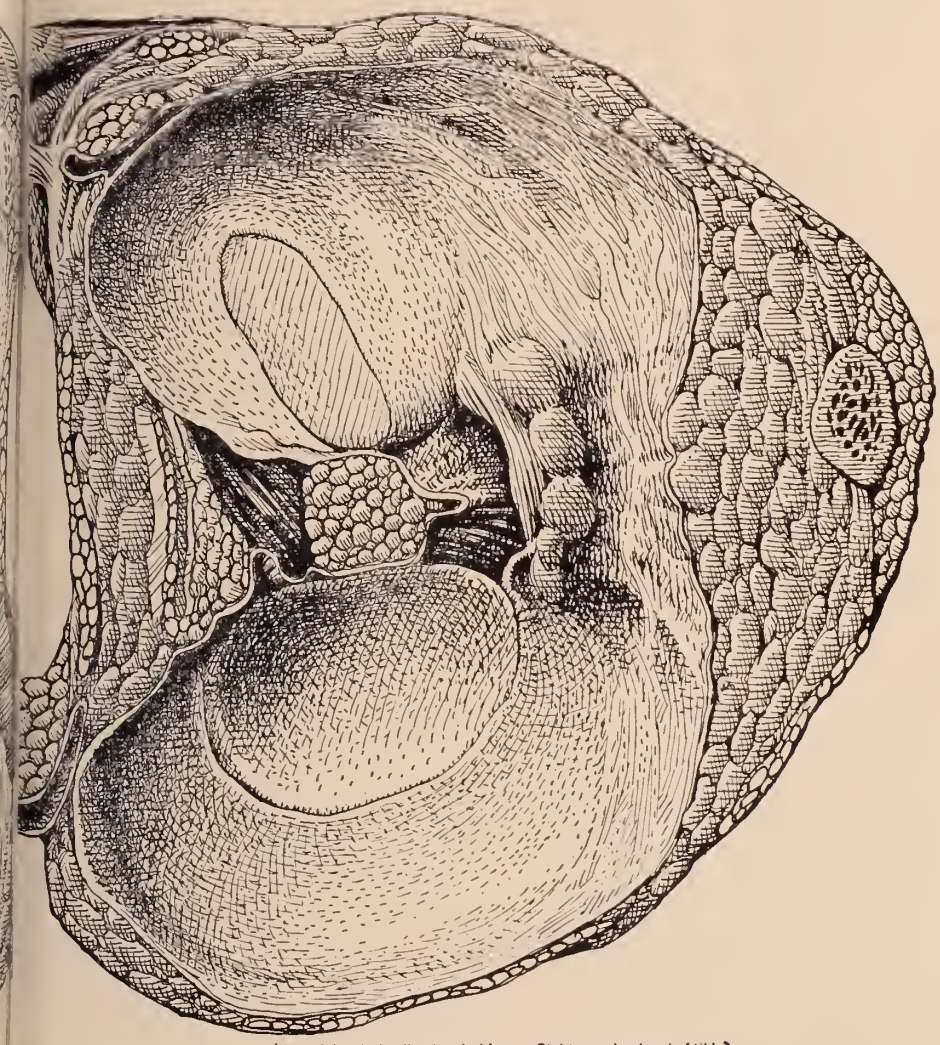
because patients are more than arthritic joints... controlling inflammatory symptoms is frequently not enough

Even cortisone, with its severe hormonal reactions, can effectively control inflammatory and rheumatoid symptoms. But a patient is more than the sum of his parts – and the joint is only part of a whole patient. Symptomatic control is but one aspect of modern corticotherapy, because what is good for the symptom may also be bad for the patient.

Unsurpassed "General Purpose" and "Special Purpose" Corticosteroid...
Outstanding for Short- and Long-term Therapy

Aristocort®

Triamcinolone Lederle



(Knee Joint, Left: distal end of femur; Right: proximal end of tibia)

ARISTOCORT is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

ARISTOCORT provides unsurpassed anti-inflammatory control without sodium retention or edema — without the undesirable psychic stimulation and voracious appetite.

Supplied: Scored tablets (three strengths), syrup, parenteral and various topical forms. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle LEDERLE LABORATORIES · A Division of AMERICAN CYANAMID COMPANY · Pearl River, New York

Plan now to attend the A.M.A. Clinical Session in Denver, November 27-30

NEW...made from 100% corn oil UNSALTED MARGARINE FOR HYPERTENSIVE PATIENTS

* contains only 10 mgs. of sodium per 100 grams
* contains 50% liquid corn oil and 50% partially hydrogenated corn oil
* has 30% linoleic acid—10 times that of butter

Because of the relationship of high-sodium intake to elevated blood pressure, new Fleischmann's Unsalted Corn Oil Margarine will prove to be a valuable addition to the dietary regimen of your hypertensive patients. It contains only 10 mgs. of sodium per 100 grams.

Fleischmann's Unsalted Margarine is made from 100% corn oil and contains both liquid corn oil and partially hydrogenated corn oil. Its linoleic acid content of 30% is three times higher than the 10% of regular margarines and ten times higher than the 3% of butter. This is the *only* unsalted margarine made from 100% corn oil.

The substitution of Fleischmann's Unsalted Corn Oil Margarine for butter or ordinary margarines in your hypertensive patients' dietary regimen has the added advantage of increasing their intake of high polyunsaturates . . . important because of their association with hypertension and atherosclerosis.

If your hypertensive patient needs sodium restriction, recommend Fleischmann's Unsalted. It has a light, delicate taste that he'll like. Tell him that it is available in his grocer's frozen food case.

Write now for physician booklet of 5 coupons—each coupon redeemable by your patient for 1 lb. of Fleischmann's Unsalted Margarine. Address Fleischmann's Unsalted Margarine, 625 Madison Avenue, N. Y. 22, N. Y. *Distribution presently limited in some areas.*

In line with the suggestion of the American Heart Association to manufacturers, we are listing the fatty acid composition of Fleischmann's Unsalted (Sweet) Margarine:

Unsaturated Fatty Acids:	
Polyunsaturates	30%
Monounsaturates	50%
Saturated Fatty Acids	20%
	100%

AVERAGE DAILY INTAKE
Two Ounces or Eight Pats of Fleischmann's Corn Oil Margarine Will Supply

Corn Oil—Liquid	22.7 Gm.
Corn Oil—Partially Hydrogenated	22.7 Gm.
Iodine Value	90-95
Sodium (dietetically sodium-free)	6 Mgs.
Linoleic Acid	13.6 Gm.
Vitamin A (Adult's Need)	47%
Vitamin A (Child's Need)	62%
Vitamin D (Adult's and Child's Need)	62%



Fleischmann's
Fresh-Frozen in the green foil package
in your grocer's frozen food case

ONLY UNSALTED MARGARINE MADE FROM 100% CORN OIL



in bacterial otitis media

Panalba* promptly

to gain precious therapeutic hours

In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

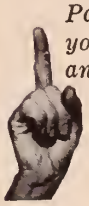
A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.
SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, and a few cases of leukopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.
CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.
*Trademark, Reg. U. S. Pat. Off.

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Panalba
your broad-spectrum antibiotic of first resort.



Upjohn

75th year

The Upjohn Company
Kalamazoo, Michigan

After 10 weeks of therapy— a clear skin, a new personality, a new world of fun and laughter

pHisoHex, used as a daily, exclusive wash, enhances any treatment for acne. Because it contains 3 per cent hexachlorophene, it supplies *continuous* antibacterial action to help combat the infection factor. pHisoHex cleanses better than soap because it is 40 per cent more surface-active.

Used together, pHisoHex and new keratolytic pHisoAc Cream provide basic complementary topical therapy for patients with acne—to unplug follicles and to help prevent comedones, pustules and scarring.

New pHisoAc Cream dries, peels and helps degerm the skin; flesh-toned, it tends to hide acne lesions as they heal.

pHisoHex, in unbreakable squeeze bottles of 5 oz. and NEW plastic bottles of 1 pint; pHisoAc in 1½ oz. tubes.

pHisoHex and pHisoAc, trademarks reg. U. S. Pat. Off.

Winthrop LABORATORIES
New York 18, N.Y.

CLINICAL PHOTOGRAPHS



Acne vulgaris before treatment

For treatment at home, this patient washed her face daily with pHisoHex and kept pHisoAc on her face twenty-four hours a day.

Nine office treatments consisted of mechanical removal of blackheads and applications of carbon dioxide slush. No other medication was given.



After 10 weeks of therapy

For Acne—pHisoHex® and

antibacterial, nonalkaline, nonirritating, hypoallergenic detergent

pHisoAc® Cream

keratolytic

How Doctors Can Become PARTNERS in Profit From Investments in Giant Real Estate!



By Mortimer L. Schultz, one of the nation's leading Real Estate Syndicators, and President and Chairman of the Board, Office Buildings of America, Inc.

Mr. Schultz, author of "Partners in Profit—The Real Estate Syndication Story," has explained real estate syndication to hundreds of college, medical, executive and real estate groups throughout the United States. The questions below are representative of those most often asked by medical investment groups and from inquiries received from doctors.

Q What is real estate syndication?

A It is a group effort which permits the small investor to purchase income producing real estate that formerly was beyond his financial reach.

Q What are current yields and how are they paid?

A Yields currently range from 9 to 15% annually, paid on a monthly basis.

Q How can syndication benefit a doctor?

A Participation in syndication is an ideal way to convert ordinary income into long term capital gains, thus lessening the investor's tax burden.

Q Give a concrete example of how ordinary income converts to long term capital gains.

A A doctor with a $36,000 investment in a Newark office building received $38,760 in cash income during the syndication's five years of existence. Of this, only $10,000 was subject to tax, on a long term capital gains basis. In addition, the doctor was permitted to write off an additional $7,000 of income from his practice due to the depreciation reserves on the particular building.

Q What is the liability of an investing partner?

A A limited partner risks his investment only. Syndication shares usually range in price from $2,500 to $5,000.

Q Are partnership interests marketable?

A Definitely yes. First Jersey Securities was the originator and is still the nation's leading secondary market for syndications. In the past, First Jersey has had no trouble re-selling these shares, usually at par or better.

Q Who is the typical syndication partner and how much has been invested in syndications to date?

A A recent survey indicates the typical investor is (a) in his forties, (b) an executive or professional man with an income of $10,000 to $50,000 and (c) with $5,000 to $35,000 invested in two or more syndications. Syndication investments throughout the country are currently increasing at an annual rate of $3 billion.

For your complimentary copy of Mr. Schultz's new book, "Partners in Profit—The Real Estate Syndication Story," please fill in the coupon below.

FIRST JERSEY SECURITIES CORPORATION
671 Broad Street, Newark 2, N. J. **MArket 3-4893**

Gentlemen:
Send a copy of "Partners in Profit" with no obligation, of course, to:

Name .....
Address .....
City ..... *State*.....



WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE®

Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine
nasal decongestant / expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®		
Dihydrocodeinone Bitartrate	5 mg.	6.5 mg.
(Warning: May be habit-forming)		
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Literature on request

Endo®

ENDO LABORATORIES
Richmond Hill 18, New York

Acts within minutes—KOAGAMIN, unlike other hemostatic agents, acts *quickly* in *minimal* dosages. Working on the late phases of the clotting mechanism, KOAGAMIN does not require massive and prolonged pre- or postoperative dosages to control capillary and venous bleeding.

Acts with predictable safety—In 20 years of clinical use, no toxic or side actions have been reported with KOAGAMIN. Bleeding is arrested without danger of thrombosis, and because KOAGAMIN contains no protein or alkaloid, it can be administered without danger of sensitization or untoward reactions.

Acts effectively in a broad range of indications—Because of its *unparalleled safety* and *outstanding effectiveness,* KOAGAMIN has been successfully employed in...hemorrhagic diseases, abnormal bleeding, blood disorders, surgical cases and trauma.

KOAGAMIN, an aqueous solution of oxalic (5 mg. per cc.) and malonic (2.5 mg. per cc.) acids for parenteral use, is supplied in 10-cc. diaphragm-stoppered vials.

CHATHAM PHARMACEUTICALS, INC · NEWARK 2, NEW JERSEY
Distributed in Canada by Austin Laboratories, Limited, Guelph, Ontario

Chatham

BEFORE, DURING AND AFTER SURGERY

KOAGAMIN®

(parenteral hemostat)

controls bleeding with minimal dosage and maximum safety

10360



Day and night–
less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

New ISUPREL® compound ELIXIR

Winthrop LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.



Calms the Tense, Nervous Patient

in anxiety and depression

The outstanding effectiveness and safety with which Miltown calms tension and nervousness has been clinically authenticated by thousands of physicians during the past six years. This, undoubtedly, is one reason why meprobamate is still the most widely prescribed tranquilizer in the world.

Its response is predictable. It will not produce unpleasant surprises for either the patient or the physician. Small wonder that many physicians have awarded Miltown the status of a proven, dependable friend.

Miltown®
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS®—400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

WALLACE LABORATORIES
Cranbury, N. J.

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Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms, liver damage or agranulocytosis
3. Does not muddle the mind or affect normal behavior



Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 10th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.

ANOTHER YEAR OF SYMPOSIA . . .

PROVIDENCE, RHODE ISLAND
Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA
Thursday, November 9, 1961
The Penn Harris Hotel

JACKSONVILLE, FLORIDA
Sunday, November 12, 1961
The Robert Meyer Hotel

ALLENTOWN, PENNSYLVANIA
Wednesday, November 15, 1961
The Americus Hotel

SOMERVILLE, NEW JERSEY
Thursday, November 16, 1961
The Far Hills Inn

NASHVILLE, TENNESSEE
Wednesday, November 29, 1961
Meharry Medical College

EDINBURG, TEXAS
Saturday, December 2, 1961
The Echo Motor Hotel

WACO, TEXAS
Sunday, December 10, 1961
The Holiday Inn

Plans for 1962 already include the following Symposia, with more being arranged:

MOBILE, ALABAMA
Friday, January 5, 1962
The Admiral Semmes Hotel

ST. PAUL, MINNESOTA
January 8, 1962
The Hotel Lowry

PORTLAND, OREGON
Wednesday, January 24, 1962
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 24, 1962
The Westward Hotel

WINCHESTER, VIRGINIA
Wednesday, March 14, 1962
The Lee-Jackson Hotel

SIOUX CITY, IOWA
Thursday, March 15, 1962
The Sheraton-Martin Hotel

SPOKANE, WASHINGTON
Saturday, June 2, 1962
The Davenport Hotel

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Plan now to attend the A.M.A. Clinical Session in Denver, November 27-30

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Providing up to

$1,000 *Monthly Accident and Sickness Benefits.*

Providing

$10,000 to **$50,000**

of Term Life Insurance.

Providing

$10,000 *Major Medical Coverage paying* 80% *of total covered medical expenses over* $500.00 *deductible.*

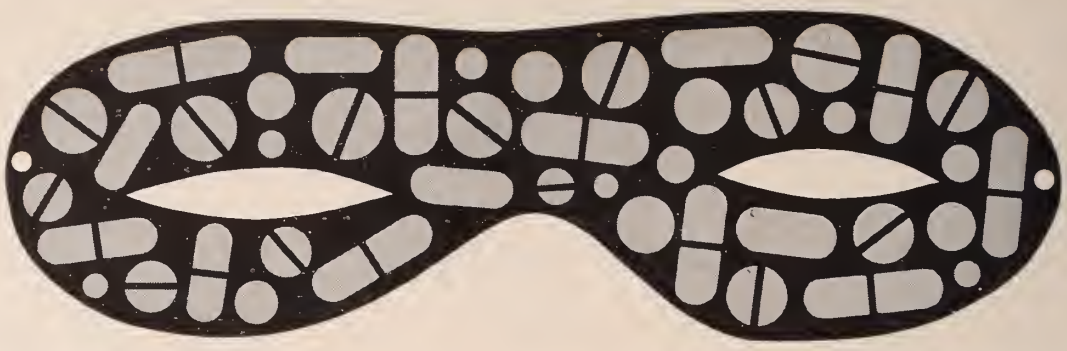
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75 Montgomery Street *Jersey City 2, New Jersey*

DElaware 3-4340



drugs anonymous

One of the several hastily conceived and potentially dangerous suggestions for reducing drug costs is generic-name prescribing. The proponents of generic-name prescribing claim that it will lower drug costs significantly and—through supervision by the Federal Government—provide quality equivalent to that of trademarked drugs. We maintain that these claims are false. Here are some authoritative answers to the principal questions posed by generic-name prescribing.

How much money would be saved if all prescriptions were written for generic-name drugs?

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Rhode Island Medical Journal,
January, 1961

Are the savings worth the risk of sacrificing quality?

". . . it is unsafe [to prescribe generically] because there is not sufficient policing of our standards. . . ."

Lloyd C. Miller, Ph. D.
Director of Revision of the U.S.P.

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formerly Medical Director of the
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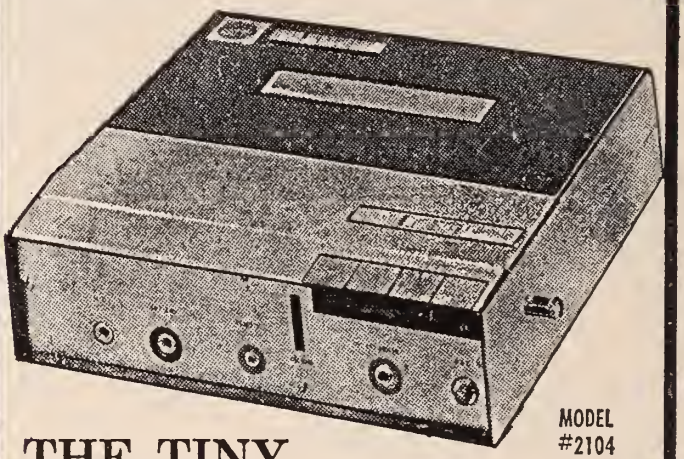
He has just made a decision that's important to you. He has analyzed some sample oranges from the grove in the background and found that they have the optimal amount of sugar, of acid, and are of the proper texture. (Testing for vitamin C comes later.) Homer Jackson knows that these oranges are of a quality to meet the exacting regulations required by the Florida Citrus Commission.

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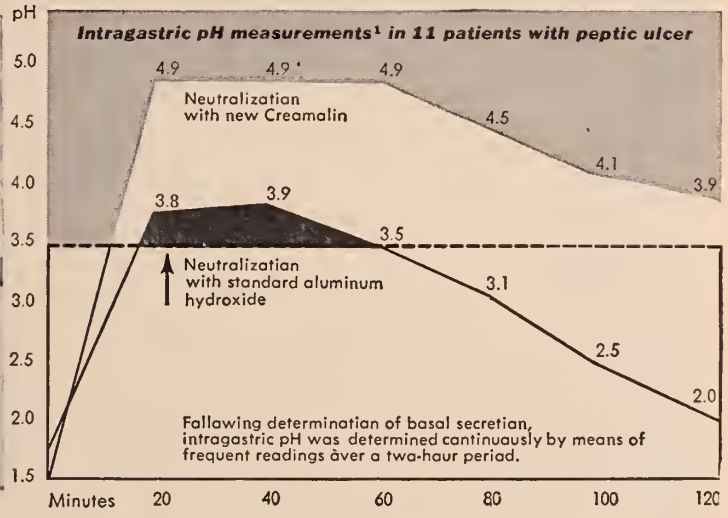
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References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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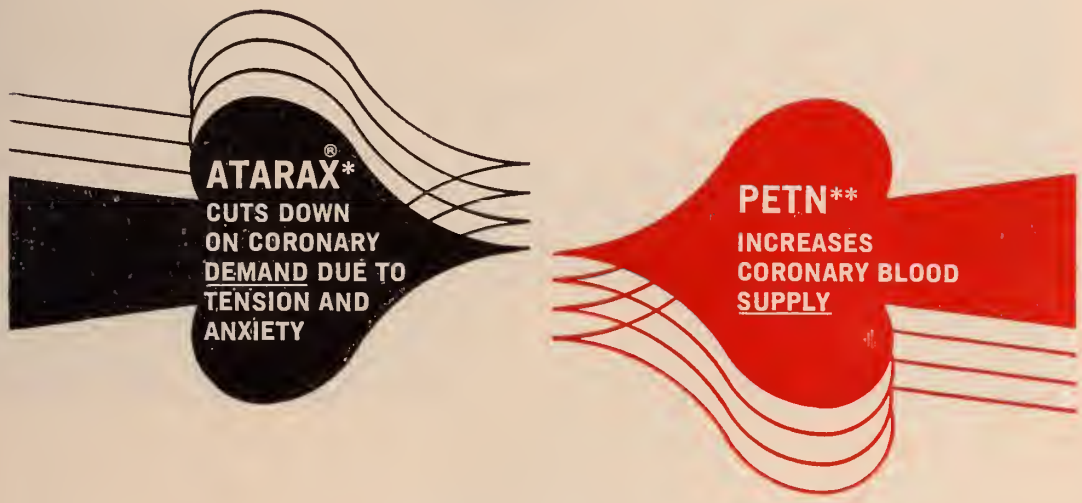
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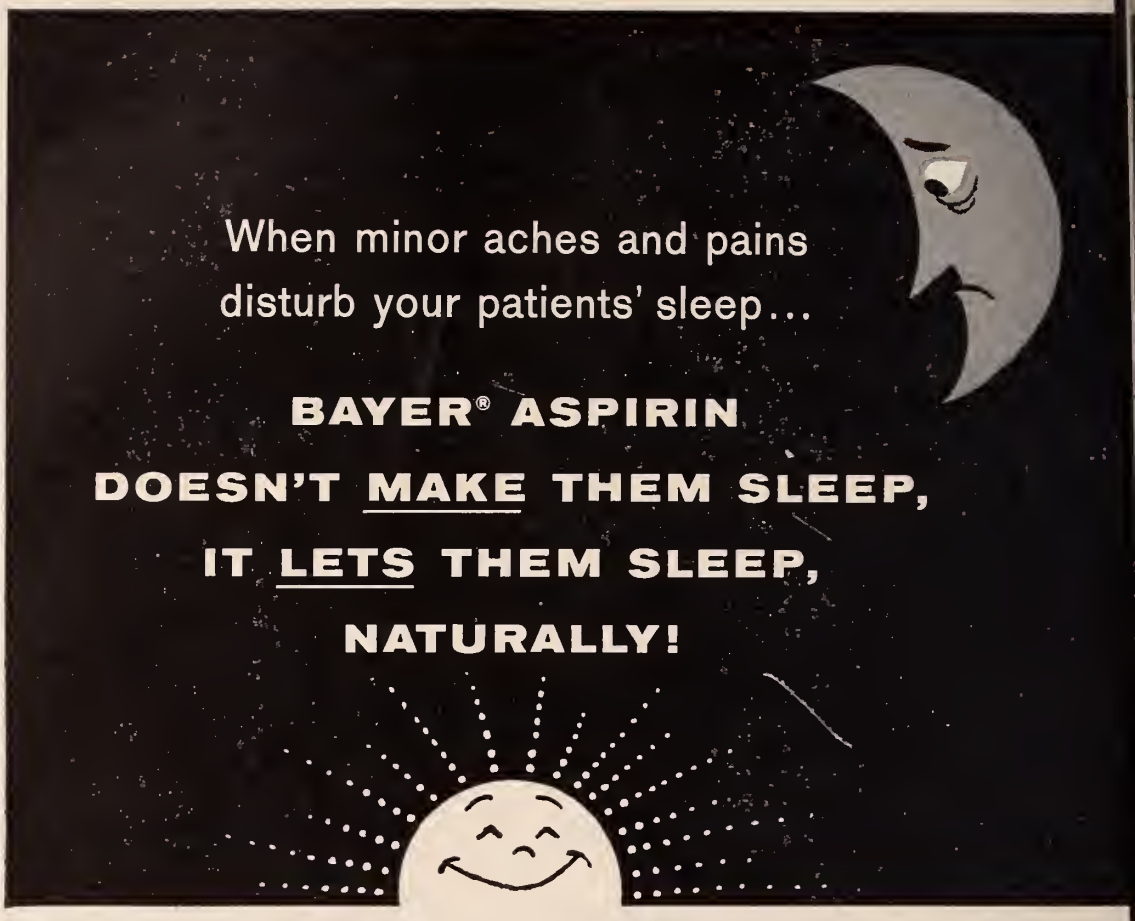
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1. Clark, T. E., and Jochem, G. G.: Angiology 11:361 (Aug.) 1960.

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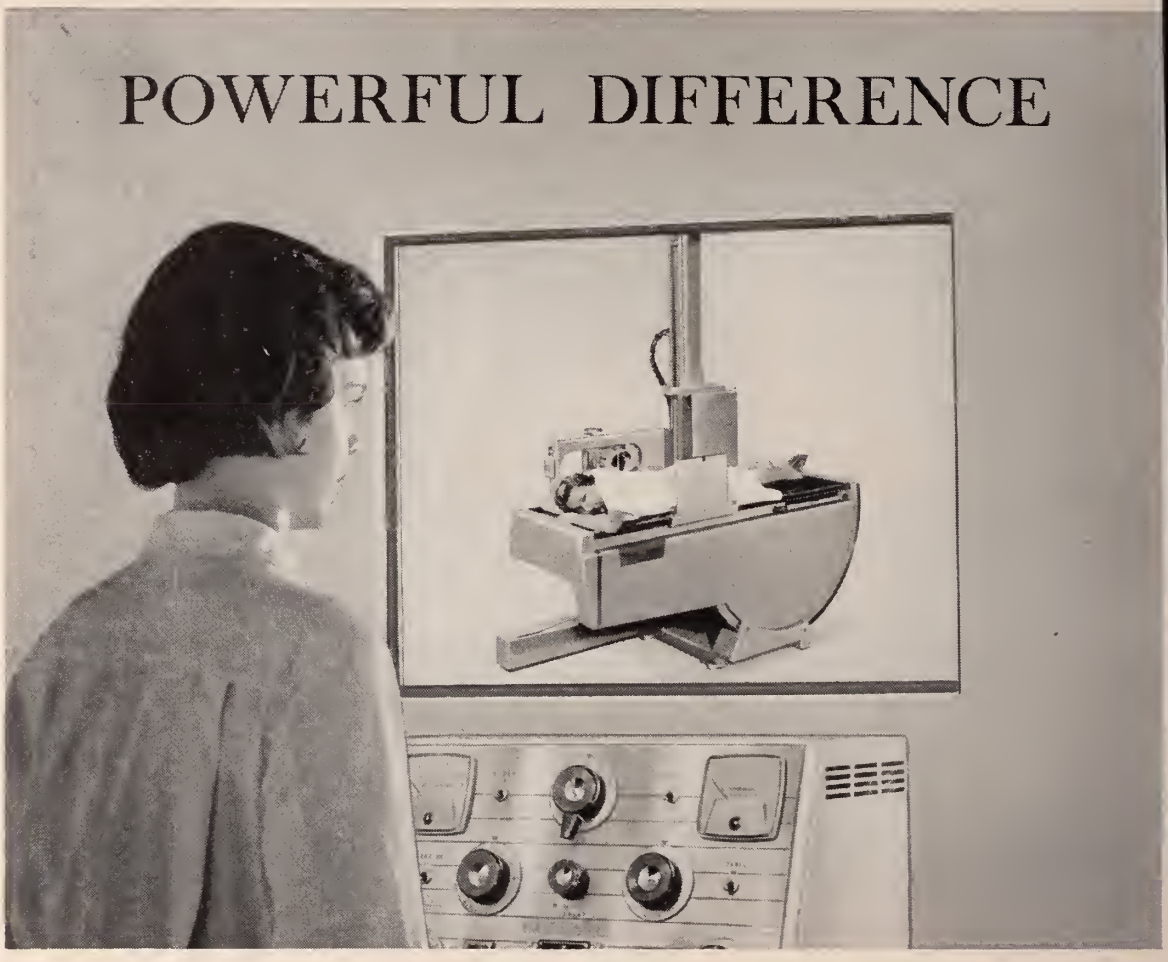
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Editorials • • •

Responsibility for Transfusion Errors

Now that hospitals have, to a large extent, lost their immunity from malpractice actions, many borderline cases are developing. Is the untoward result the fault of the attending physician—or of a hospital employee? If anesthesiology is the practice of medicine, the responsibility is clear. But if the anesthesiologist is a hospital employee—or if the anesthesiologist can employ, on his private payroll, a staff of anesthetists, then the question of liability becomes more complicated. In this connection the following case is cited in the July 1, 1961, *New York State Journal of Medicine*.

A circulating nurse had mistakenly brought a pint of blood to the operating room where the decedent was undergoing surgery. *Neither the surgeon nor anyone else in the operating room had ordered blood for the patient.* The blood was given to a nurse anesthetist (an employee of the anesthesiologist). The circulating nurse and the anesthetist failed to check the slip on the bottle which showed that the blood was intended for another patient. The anesthetist advised the surgeon that he had blood ready and asked if he should give it. The surgeon told him to do so. The surgeon, it was claimed, should never have permitted the blood to be given when he knew that he had not ordered it.

The Court of Appeals in its majority opinion stated as follows:

> The proof showed that he "initiated the blood bank in the Hospital"; that it was hospital procedure to prepare a *written order* for the production of blood for transfusion purposes during the course of any operation (except in emergency situations, concededly not present here); and that "Nobody can order blood to the operating room except the Doctor"; that he had not ordered "the production of the blood in the operating room at that time," and he knew that he had not ordered it—indeed, it had occurred to him at the time to "inquire as to how that blood got to the operating room," but he did not do so.
>
> The jury thus had a right to find that in ordering the blood transfused without question and

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 687

VOL. 58, NO. 11 NOVEMBER, 1961 Subscriptions, $3.00 per year
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under these circumstances, defendant surgeon had breached his duty of reasonable care to plaintiff's decedent.

One Judge dissented and felt that the surgeon should not be held liable. Judge Van Voorhis said:

> Under the rules of the hospital *it was the responsibility of the hospital and not that of the attending physician* to prepare and administer blood transfusions. The responsibility of the attending physician was confined to making decisions whether transfusions should be given, and directing the hospital to give them. To make certain that transfusions will not be given in cases where the attending physician has not directed them to be administered, the rules of the hospital provide that they shall be given only on the written order of the physician. When a written order has been given, *all the rest is done by the hospital.* If . . . [the surgeon] had given a written order for a transfusion in this instance, transfusion would have been administered exactly as it was without further participation by . . . [the surgeon]. The only act of negligence ascribed to . . . [the surgeon] is that not having previously ordered the transfusion by written order, he should have become suspicious that something was wrong and checked on whether the hospital had performed its responsibilities in the preparation of the blood for transfusion. If he had given a written order the entire responsibility for typing, crossmatching and administering the transfusion would have been upon the hospital. The attending surgeon would have been absolved from all responsibility in connection with its preparation and administration. The circumstance that, insofar as . . . [the surgeon] was concerned, his need for a transfusion appeared to have been anticipated by the hospital does not seem to me to have changed this responsibility.

Even the majority did not predicate liability on the theory that the surgeon is "captain of the ship" and, therefore, responsible for everything that happens in the operating room.

The case highlights the growing diffusion of responsibility when the hospital appears as a third party, and not—as in the old days—when the hospital was simply the hotel for the sick. Now that the hospital plays a dynamic role in direct care, division of responsibility is inevitable. The law is not yet ready, it seems, to abandon the position that anesthesiology, roentgenology and pathology are parts of the practice of medicine. At least when it comes to fixing responsibility, this is all considered medical practice.

Can TB Be Conquered?

The fight against tuberculosis has progressed far enough for us to be thinking about wiping out tuberculosis, not just controlling it. To start, we must find every person in New Jersey with active disease and treat him adequately. That's a tall order. Last year there were 1,651 New Jersey residents with active and probably active tuberculosis.

Our case-finding efforts cannot stop with the people who voluntarily take part in chest x-ray surveys. Do *you* routinely give a Mantoux test as part of every physical examination?

Also in New Jersey, there are thousands of former tuberculosis patients who were treated before modern drugs became available. Any one of them might relapse into active disease. Many of them must be treated with modern drugs to avoid relapse.

As more and more active cases of tuberculosis are found and treated, the incidence of new infections naturally goes down. The tuberculosis associations of New Jersey have as their goal 9 per cent fewer new cases of tuberculosis every year for the next ten years.

Your Christmas Seal contributions will help the attainment of this goal.

Profits . . . and Risks . . . in the Pharmaceutical Industry*

The American pharmaceutical industry, now a whipping boy, sometimes makes excellent profits and pays high returns on investments. What is less well known, however, is that it often suffers serious losses—and takes these losses when a less conscientious industry might have recouped something. For example, there is the story of Lederle's 30,000 rabbits. Lederle in 1935 had the world's largest rabbit warren. These 30,000 rabbits were used to produce a new pneumonia serum.

Pneumonia then was a real killer. Scientists had long sought a remedy. Lederle was the first to find it. A nationwide distribution system was set up. The costly research program was about to pay off. At that point, the sulfa drugs were introduced. They did the job better. The market for serum disappeared. Every dollar of the millions spent for this research had to be written off. From its serum making, Lederle derived little except the satisfaction of having saved countless thousands of lives.

This is typical of what can happen in the high risk drug industry. Tremendous changes occur overnight. Company sales and earnings show wide fluctuations from one year to the next. Thus, in 1957, Schering, a leader in the corticosteroid market, achieved record sales with Meticorten® and Meticortelone®. Then three major competitors entered the field. Schering's earnings dropped 23 per cent in two years.

Lakeside Laboratories set new records with antispasmodics and diuretics until other companies introduced new products in the fields. In 1958, Lakeside earnings tumbled and in 1959, the company reported a deficit of $40,000.

In 1958, nearly a quarter of the age group most susceptible to poliomyelitis had not received any vaccine at all. Despite this, sales of vaccine dropped sharply. Lilly then shut down its poliomyelitis vaccine plant for three months. Earnings fell in 1958 and continued to decline in 1959. Allied Laboratories, which made huge quantities of poliomyelitis vaccine, experienced a 46 per cent drop in earnings in 1958.

A decision *not* to market a drug can be costly. Smith Kline and French once developed a new product to prevent vomiting and to control certain psychotic manifestations. A hundred internists tried and dubbed the new remedy "excellent." Smith Kline and French concluded, however, that it was not significantly better than others already on the market. And it had some questionable "side effects." So, three-quarters of a million dollars in research and development funds went down the drain when the company decided not to market it.

Research, lifeblood of a pharmaceutical company, is its biggest gamble. The researcher never knows where his experiments will lead. The company never knows how commercially valuable the research will prove to be. Only one of every 3,000 substances investigated is likely to be found worth marketing. Many companies have sunk vast sums in projects that did not turn out. Lilly's long and expensive investigation of cortisone came to nothing. Carbutamide for diabetes, was another Lilly disappointment. Although carbutamide controlled many cases of diabetes, a meticulous clinical survey costing $850,000 turned up so many side effects that Lilly abandoned the product.

When a new product lives up to expectations, rewards can be great. This is always the mark of a high-risk venture. The history of profits in the pharmaceutical industry shows that what goes up can come down, often at dizzy speed.

*This editorial is adapted from information in an August, 1961 release prepared by Smith Kline and French.

HYMAN W. FISHER, M.D.
Livingston

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ROBERT BONDA, D.D.S.
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LESTER A. BARRER, M.S.
West Orange

Validity of Radiation Protection Standards*

Re-Evaluation of the Radium Dial Painters

Our biologic future may depend on our understanding of, and mastery over radium hazards. Every physician has a duty to cooperate in this study. Please see the last paragraph.

RADIUM is the only internal emitter for which there is a significant experience with long-term effects on humans. Radiation protection standards for all radioactive isotopes incorporated into body tissues are based on experience with radium. For isotopes other than radium, animal experiments or calculations of relative biologic effectiveness from physical characteristics of the isotopes in question, are used to extrapolate the basic radium data.

It is vital for us to know the long-term effects of internal emitters, and to set safety standards on as secure a basis as possible. The present radium standard has been based on the study of a relatively small proportion of all available radium cases. As of 1931, Martland[1] had cited 18 radium deaths and mentioned 30 patients alive at that time. In 1956, Looney[2] reported on 50 cases from the Chicago and Boston areas, some of these were the same ones mentioned by Martland.[1]

It is estimated that in the New Jersey, metropolitan New York and Philadelphia areas alone, more than 1000 persons were exposed to radium and a few other isotopes 35 to 45 years ago. Of these, several hundred are probably still alive, and have not yet been studied. In 1957, the New Jersey State Department of Health (under a contract with the United States Atomic Energy Commission) instituted an epidemiologic search for and study of all former dial painters and others exposed to radium. Until that time, only those who became "sick" with what was recognized to be radium poisoning had been studied, with few exceptions.

Most of the radium cases are to be found among former dial painters, the largest group of which actually worked in New Jersey. Other

*This Project is supported by the U.S. Atomic Energy Commission Contract No. AT(30-1)-2181. From the Radium Research Project of the New Jersey State Department of Health, Lester A. Barrer, M.S., Project Director, 11 Washington Street, West Orange, N. J. This paper was read before the Sections of Medicine and Ophthalmology of The Medical Society of New Jersey, Atlantic City, May 17, 1961.

1. Martland, H. S.: Am. J. of Cancer, 15:2435 (1931).

2. Looney, W. B.: J. of Bone and Joint Surg., 38-A:175 (1956).

occupational exposures to radium occurred among physicists and chemists, and clerical, maintenance and office staffs. Some persons acquired their body burdens during medical treatment or diagnosis with radioactive materials, including Radithor® and Thorotrast®. Many persons used nostrums which contained radium or radon, for inhaling, drinking, or bathing. Some persons were contaminated as a result of radiation accidents, or through use of radio-luminescent paints. A well-studied group of radium cases were 39 psychotic patients at the Elgin State Hospital in Illinois[3] who received radium intravenously during the years 1930 to 1932. The radium dial painter cases were exposed from the time of World War I to about 1925.

METHODS

At the inception of the Radium Research Project in New Jesery, we spent two years in case finding. No employment records from the radium plants were available, and it was a laborious task of field investigation to find names of possible radium cases and to track down these names through the intervening years after exposure. Death certificates were needed for those who had died. A study of their medical histories is being assembled. Those still alive had to be traced to their present addresses. Then the persons had to be reached and induced to undergo the studies.

In late 1959, the present clinical and radiation studies were begun in a concentrated manner. As of the end of 1960, about 80 cases had been fully studied and another 50 started through the studies. A list of a hundred or more additional living subjects is available. New cases are constantly being found.

The protocol for the basic study of a living radium case by the Radium Re earch Project is extensive. It includes a medical history and physical examination; laboratory studies of hematology, chemistries, serology, urine, and exfoliative cytology; a radiographic bone survey; a dental history, clinical examination and radiographic survey of the teeth and jaws; and determination of body burden of radioactive materials. This last aspect is done *in vivo* both by measuring radon in exhaled breath and by measuring total external gamma radiation from the body in a whole body counter.

KNOWN EFFECTS OF RADIUM

Martland[1] reported that deaths from radium four to six years after exposure were due to jaw necrosis and aplastic anemia. From 1924 to 1928, two deaths were due to bone sarcomata. From 1928 to 1931 additional bone sarcomata developed and other symptomatic and asymptomatic bone lesions were noted.

Groups at the Massachusetts Institute of Technology and Argonne National Laboratories and Cancer Research Hospital have been conducting studies in their respective areas which parallel those under way in New Jersey. In 1952, the Boston group reported 30 cases, among which were 8 malignancies: 3 osteogenic sarcomata, one giant cell tumor of bone, one fibrosarcoma of a knee joint capsule, and 3 epidermoid carcinomas of paranasal sinuses.[4]

The present maximum permissible body burden in the total body (using bone as the organ of reference) is 0.1 microgram of radium. In the Massachusetts series the carcinomata all arose in patients with body burdens greater than 1 microgram.[5] The incidence of symptoms and signs of radium effect increased with increasing residual body burdens above about 1 microgram. There were a few symptoms referable to radium poisoning with levels of 0.5 to 1 microgram. No case with a level lower than 0.5 microgram had symptoms unequivocally attributable to radium.

3. Looney, W. B., Hasterlik, R. J., Brues, A. M. and Skirmont, E.: Am. J. Roentgenology and Radium Therapy, 73:1006 (1955).

4. Aub, J. C., Evans, R. D., Hempelmann, L. H. and Martland, H. S.: *Medicine*, 31:221 (1952).

5. Evans, R. D. and Dudley, R. A.: Radiation Protection Criteria and Standards: Their Basis and Use. Summary-Analysis of Hearings. Special Subcommittee on Radiation of the Joint Committee on Atomic Energy, Congress of the U. S., Gov't. Printing Office, Washington, October 1960. Pages 66 and 67.

RESULTS

Correlation of findings with body burdens in our cases will not be presented at the present time, because of the preliminary nature of this report which covers about 80 cases only. We anticipate eventually studying several times this number of cases.

Six cases under study by our project died during 1959 and 1960. One died of myelofibrosis, with extramedullary hematopoiesis, with no evidence of leukemia. Another (who had had carcinoma of the cervix treated in 1943) died primarily because of hypertensive and arteriosclerotic cardiovascular-renal disease. A third subject died of disseminated squamous cell carcinoma of the buccal mucosa. He also had an independent squamous cell carcinoma of bronchial mucosa. The fourth patient had reticulum cell sarcoma of the spinal cord. The fifth died of advanced arteriosclerotic cardiovascular disease. He had had a cerebral vascular accident in 1956. The sixth subject died following pulmonary and vascular complications of elective surgery for a benign ovarian cyst. Interstitial pulmonary fibrosis and hyperplastic bone marrow were found postmortem.

In addition to these four malignancies among three of the deaths (cervix, buccal and bronchial, and spinal cord), and the myeloproliferative disorder (myelofibrosis), another six malignancies exist in the cases still living. These include another cervix carcinoma, 2 basal cell carcinomata of skin, a scirrhous carcinoma of breast, an osteogenic sarcoma of a tibia, and a parosteal osteogenic sarcoma of a tibia. Of these malignancies, only the patients with the osteogenic and parosteal osteogenic sarcomas had body burdens greater than the maximum permissible body burden of 0.1 microgram.

A number of "precancerous," benign or tumors of undetermined type were also encountered. These included 5 rectal polyps and 9 goiters. The goiters were: one diffuse nontoxic; 4 multinodular non-toxic, 2 toxic adenomata; and 2 thyroid masses of undetermined type. There were also 10 uterine fibroids; 10 prostate enlargements; 1 erythroplasia of Queyrat; 1 probable acoustic neurinoma; 1 probable tumor of the cervical spine; and 1 breast mass.

Among the laboratory studies, two abnormalities have been frequent: (a) an increased erythrocyte sedimentation rate and (b) nonconsistent alterations in serum globulin patterns. The significance and cause of these abnormalities is not known.

Among the radiographic studies of bone (aside from those of the neoplasms mentioned above) the most dramatic have been multiple bone defects in 21 cases and alterations of trabecular structure in 15 cases. The bone defects have been oval or irregular, discrete or coalescent, situated in the cortex and/or medulla, and variable in size. Changes in trabeculae have included blurring or destruction, thickening or sclerosis, irregularities in pattern, or coarsening. Periosteal thickening and/or irregularities have occurred in 15 cases. Although 18 fracture residua have been detected on x-rays, and several more mentioned in medical histories, only one pathologic fracture has been encountered in our series. As with other medical findings, differential diagnosis of bone lesions must be considered. A meticulous history, physical examination, and indicated laboratory studies help resolve diagnostic difficulties.

The most important dental findings have been radiographic, occurring much more frequently in the mandible than in the maxilla. There is a high incidence of disturbed calcification and disturbed trabecular pattern. These changes are by no means specific for radium poisoning. Of particular note are the cases with areas of rarefaction in the body of the mandible, involving or superior to the inferior cortex, and irregularities of the inferior cortex.

FUTURE PLANS

Only a few of the many abnormalities encountered among our cases have been mentioned. Because this is a group of people who are for the most part over 55 years old, many findings related to the aging process are pres-

ent. Whether the aging process has been affected by the body burdens of radioactive materials will have to be determined after a large number of radium cases and a suitable control population have been studied. Our plans include the review of additional radium cases with more extensive studies on some of the cases and a parallel study of a control population. We are accumulating and studying specimens from autopsies which will yield data regarding sites of localization of radioactive materials, histologic changes, and correlations of histologic with radiographic changes. Specialized histochemical, autoradiographic and radiochemical studies are under way. It is anticipated that much invaluable information which can be obtained from no other source will be developed from our studies.

PHYSICIANS' ASSISTANCE REQUESTED

ALTHOUGH the Project personnel are searching all possible leads to new radium cases, the assistance of all physicians is needed. Please refer to the Project any person who may have retained radioactive substances for long periods of time. Several hundred radium subjects still alive are not yet known to the Radium Research Project. Anyone having information about such cases is urged to report them to the Project at 11 Washington Street in West Orange, New Jersey. All information will be kept in strict confidence, and all data obtained in our study will be sent to the personal physician of the patient or subject concerned.

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Thyroid Reduces Blood Cholesterol

Writing in the August 22 (1959) British Medical Journal, B. O. Barnes points out that thyroid therapy reduces blood cholesterol levels in patients afflicted with hypercholesteremia or myocardial infarction. Another 15 to 20 years are needed, however, to determine whether thyroid therapy can prevent arteriosclerosis.

Eighty patients selected from 700 apparently normal adults seen in general practice were treated. The 80 had blood cholesterol higher than 200 milligrams per 100 milliliters. They were given thyroid in doses varying from 65 milligrams to 260 milligrams daily; 130 milligrams was the modal dose. The cholesterol level was determined two or three months later and if above 200 milligrams, the thyroid dosage was increased.

The initial blood cholesterol levels ranged from 200 milligrams to 381 milligrams per 100 milliliters, with an average of 242 milligrams. Patients' ages ranged from 32 to 79 with an average of 45. After treatment, average blood cholesterol was 180 milligrams and the range was 147 to 241 milligrams. The level did not fall below 200 in five cases.

Four cases of myocardial infarction were followed during thyroid therapy. Blood cholesterol levels declined and three of the four patients were alive three, four, and nine years after institution of treatment. The fourth, who was 70 years old when treatment began, died of a stroke and secondary coronary thrombosis a year and a half after treatment began.

The thyroid therapy method is simple, inexpensive, maintains normal cholesterol levels for indefinite periods and is harmless. It produces effects which might benefit arteriosclerosis. Normal circulation time can be restored. Blood flow through coronary arteries can be increased. That may be more important than the reduction of cholesterol. Finally, on the basis of this study, any damage to the heart from thyroid therapy apparently stems from severe overdosage.

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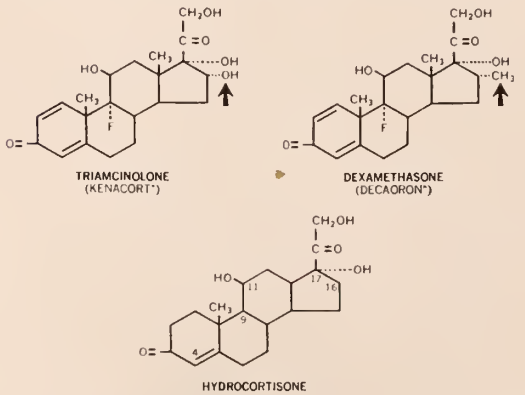
Corticosteroid Therapy in Arthritic Patients with Hypertension and/or Cardiac Disorders

Comparative Study of the Effects of Triamcinolone and Dexamethasone

In contrast to the more usual corticosteroids, dexamethasone and triamcinolone are helpful in arthritis without leading to sodium or water retention.

The present investigation was undertaken to study the use of triamcinolone in hypertensive patients with or without cardiac disturbances, to evaluate its safety and to compare its effects with those of dexamethasone, particularly with regard to sodium excretion and diuresis.

Both triamcinolone* and dexamethasone† are fluorinated steroids which chemically resemble hydrocortisone and which are similar to the known corticosteroids in their biologic properties. Orally or intra-articularly, triamcinolone has marked anti-inflammatory, antipruritic, antirheumatic and anti-allergic potency. Milligram for milligram, triamcinolone given orally has been reported to be approximately twice as potent in anti-allergic [4,5,11,12] and anti-inflammatory activity as either prednisolone or prednisone and 20 to 60 per cent more potent than prednisolone in antipruritic activity.[11] During the initial few weeks of administration, triamcinolone frequently induces sodium [6] and water diuresis.[7] This may be pronounced in patients who have been storing increased amounts of sodium and water during maintenance therapy on prednisone or prednisolone. Triamcinolone [6] has been shown to have a diuretic[7] effect on patients who have not previously received corticosteroids.[11] It appears that a decrease in body weight in most patients on triamcinolone is the result of a loss of extracellular fluid.



Occasionally hypertension occurs in patients after they are given hydrocortisone or prednisolone. No elevation in blood pressure has been observed after the administration of the usual therapeutic doses of triamcinolone.[1,3,5,10,11] On the other hand, one investigator [12] reported that three patients with hypertension who received triamcinolone experienced a *fall* in blood

*Supplied by E. R. Squibb & Sons, New York, N. Y., as Kenacort®.
†Supplied by Merck Sharpe & Dohme Research Laboratories Division of Merck & Co., Inc., Rahway, N. J., as Decadron®.

pressure level. Another [13] found no changes in blood pressure in hypertensive patients who were given triamcinolone as an anti-allergic measure.

Dexamethasone has a high degree of anti-inflammatory activity when given in therapeutic dosages. Liddle,[9] who recently studied the effects of the anti-inflammatory steroids on electrolyte metabolism summarized his findings as follows:

"There is no necessary correlation between the anti-inflammatory activity and the electrolyte-regulating activity of steroids. Steroids may induce Na+ retention and K+ loss by promoting the renal tubular cation-exchange process through which Na+ is reabsorbed from K+, and H+ secreted into the tubular urine. Steroids may induce Na+ loss by (1) inhibiting the action of aldosterone upon the renal tubules, (2) increasing glomerular filtration rate, or (3) correcting a pathologic stimulus to hypersecretion of aldosterone. Studies of structure-function relationships of the synthetic anti-inflammatory steroids have indicated that, in general, the tendency of corticosteroids to promote Na+ retention and K+ loss is greatly enhanced by introduction of a halogen atom into 9α position of the corticosteroid nucleus, slightly decreased by 1,2-dehydrogenation, and greatly diminished by introduction of a hydroxyl or a methyl group in position 16."

Barach and Pons,[2] in discussing the use of anti-inflammatory steroids in the treatment of pulmonary emphysema and cor pulmonale, suggest that

"The therapeutic activity of corticosteroids in the control of refractory cardiac failure may depend in part on a diuretic action that results from their ability to increase the glomerular filtration rate. (Reimer, A.: Scientific Exhibit, 100th A.M.A. Meeting, N. Y.) The steroid compounds may maintain the structural integrity of capillaries and hence prevent fluid loss from the intravascular spaces; the consequent increase in plasma volume may augment the glomerular filtration rate and thereby promote diuresis. The diuretic effect was found to be more marked in the delta-1 compounds, such as prednisone, than in the cortisone-hydrocortisone compounds that have an antagonistic sodium-retaining action. Reimer suggested that steroids could exert their diuretic action by suppressing the output of other adreno-cortical steroids, such as aldosterone, and thereby inhibit the sodium retention caused by the excess of aldosterone that may occur in heart failure. There is evidence that steroids also have inhibitory actions against pituitary antidiuretic hormone. (Forsham, P. and Thorn, G. W.: The Adrenals. In Textbook of Endocrinology, 2nd edition, Saunders, Philadelphia, 1955)."

THE PATIENTS

MANY patients have an arthritic disturbance accompanied by cardiovascular disease. There has been some hesitancy, however, in treating their arthritic conditions with corticosteroids because of the possibility of sodium and fluid retention. The introduction of triamcinolone and dexamethasone seems to be of particular importance in the management of these patients. To explore this possibility, triamcinolone and dexamethasone were given to 52 patients with arthritis complicated by cardiac or cardiovascular disorders. The age groups and sex and the number receiving each corticosteroid are given in Table 1. All but one of the patients were Negroes.

TABLE 1.

SEX AND AGE DISTRIBUTION OF PATIENTS FOR EACH DRUG USED

		Number of Patients	
Age Group	Sex	Triamcinolone	Dexamethasone
35 - 60	M	3	2
	F	11	11
61 - 70	M	1	2
	F	4	7
70+	M	1	0
	F	7	3
Totals		27	25
		52	

Arbitrarily, beginning with triamcinolone, the two corticosteroids were given to alternate patients. All of the patients were ambulatory except one. Most of them (81 per cent) were in good general physical condition. Many of the patients studied had relatively acute arthritis or arthritic conditions of relatively short duration (Table 2).

TABLE 2.

DURATION OF PATIENTS' ARTHRITIC CONDITION AND DRUG USED

Duration of Illness Previous to Present Therapy	Number of Patients Given: Triamcinolone	Dexamethasone
1 to 4 weeks	8	6
1 to 12 months	7	7
1 to 10 years	11	10
11 to 20 years	1	2

All of the cardiac or hypertensive conditions had been present for six months or more before the study was begun. The complicating cardiovascular condition may have been a pre-existent one, sometimes of many years' standing. All patients in this study were known to be hypertensive or to have other cardiac disorders. The cardiovascular and cardiac disorders are given in Table 3.

TABLE 3.

COMPLICATING HYPERTENSION AND/OR CARDIAC DISEASE AND THE CORTICOSTEROID USED

Diagnosis	Number of Patients Receiving: Triamcinolone	Dexamethasone
Hypertensive cardiovascular diseases	18	20
Arteriosclerotic hypertensive cardiovascular disease	5	4
Coronary heart disease	2	1
Hypertensive thyrotoxic cardiovascular disease with decompensation	1	0
Arteriosclerotic cardiovascular disease with cerebral hemorrhage	1	0

Nine patients were in decompensation and, of this number, 6 were treated with triamcinolone and 3 with dexamethasone.

TREATMENT

THE present study was concerned with short-term therapy, the duration of treatment being from 10 to 54 days, with an average of 27 days.

TABLE 4.

DURATION OF TREATMENT WITH EACH CORTICOSTEROID

Duration in Days	Number of Patients Treated with: Triamcinolone	Dexamethasone
Under 13	0	1
14 - 20	8	9
21 - 30	6	7
31 - 40	8	7
41 - 50	4	1
54	1	0

The patients received corticosteroid therapy only long enough to alleviate the symptoms or control the arthritic condition and to permit gradual withdrawal of the corticosteroid. Since patients sometimes did not return for further treatment once their arthritic manifestations were cleared up, gradual withdrawal of the corticosteroid was not always feasible.

Other antirheumatic or anti-arthritic drugs were used in conjunction with corticosteroid therapy. These are listed in Table 5.

TABLE 5.

CONCOMITANT THERAPY

Other Treatment	Patients Receiving: Triamcinolone	Dexamethasone
Intravenous sodium salicylate sodium iodide and colchicine	18	19
Antihypertensive drugs and/or diuretics	28	20
Antacids or anticholinergics	19	20
Sedatives and analgesics	14	9
Cardiac drugs and/or coronary dilators	6	6
Weight reduction agents	3	6
Antibiotics	2	1

All patients received one or more drugs besides the corticosteroid. In many instances, the drug taken concurrently was one which the patient had received prior to as well as at the beginning of the study.

RESULTS

RESULTS of treatment are summarized in Table 6.

In general, results with both triamcinolone and dexamethasone were good. Frequently patients showed marked improvement after only a few days of treatment. Most of the patients had shown signs and symptoms of arthritic disorders for only a relatively short period of time. The longer the duration of the disturbance before the onset of treatment, the

TABLE 6.

THERAPEUTIC RESULTS

Results	Number of Patients on: Triamcinolone	Dexamethasone
Conditions in which corticosteroid therapy was indicated (*i.e.*, arthritis)		
Very good	3	None
Good	21	19
Fair	2	6
Poor	None	None
Good with recurrence	1	None
Cardiovascular or cardiac conditions when corticosteroids were used with concomitant drugs.		
Very good	3	1
Good	19	17
Fair	5	5
Poor	None	2
Good with recurrence	None	None

TABLE 7.

SYSTOLIC BLOOD PRESSURE DETERMINATIONS

	Patients on Antihypertensive or Diuretic Drugs		Patients Not on Antihypertensive or Diuretic Drugs	
	Triamcinolone	Dexamethasone	Triamcinolone	Dexamethasone
Blood pressure -reduction (mm. Hq)				
Over 50	6	4	0	0
30 - 49	8	5	1	6
10 - 29	6	4	4	4
Under 10	1	0	0	4
-increase (mm. Hq)				
8	0	1	0	1

less impressive were the results and the longer was the required duration of treatment with corticosteroid.

The data (in Table 6) show that triamcinolone produced slightly better results than dexamethasone. It would appear that triamcinolone and dexamethasone enhance the action of some antihypertensive and/or diuretic drugs. Especially in patients not previously on corticosteroid therapy, both triamcinolone and dexamethasone show a definite natruretic and diuretic property, in confirmation of the findings of McGavack[10] *et al.* Diuresis becomes more marked and there is a more dramatic drop in blood pressure when triamcinolone or dexamethasone is used in conjunction with antihypertensive or diuretic drugs. This study also shows that these corticosteroids alone—without the use of an antihypertensive diuretic-type drug—will frequently produce diuresis and reduce blood pressure in patients with more moderate disturbances. Triamcinolone or dexamethasone did not produce deleterious or accentuating effects on the existing cardiovascular complications in any patient. In fact, there was a slight increase in blood pressure during treatment in only two patients (Table 7).

SIDE EFFECTS

LITTLE or no toxicity occurred with either triamcinolone or dexamethasone. Of the 27 patients receiving triamcinolone, 21 showed no evidence of toxicity. Of the 25 on dexamethasone, 8 showed no sign of toxicity. None of the side effects (see Table 8), was sufficiently severe to warrant discontinuance of the medication. Even in patients whose conditions

TABLE 8.

TOXICITY OR SIDE EFFECTS

Side Effect or Toxic Reaction	Number of Patients on: Triamcinolone	Dexamethasone
Gastro-intestinal symptoms relieved by concomitant therapy	6	11
Increased appetite	6	6
Muscle cramps	4	2
Generalized fluid retention and weight increase	1	5
Malaise or weakness	2	3
Anoxia	3	1
Gastro-intestinal symptoms not relieved by concomitant therapy	0	3
Blood sugar increase	1	1
Diarrhea	0	1
None	21	8

were fair or poor, the most frequently encountered side effect or toxicity was a gastrointestinal disturbance, usually relieved with antacids or anticholinergics.

COMMENT

Good results of short-term therapy with triamcinolone and dexamethasone in the more acute forms of arthritis with cardiovascular or cardiac complications indicate that these corticosteroids may be safely used in out-patients. Triamcinolone and dexamethasone are useful in the treatment of these patients. When judiciously administered, their side effects or toxic effects are minimal. The patients in this study were not, of course, cured of their arthritis; but there was an amelioration of symptoms and improvement in musculoskeletal function without aggravation of cardiovascular symptoms, and, in many instances, with improvement of cardiovascular difficulties.

Hollander [8] reported that triamcinolone was particularly useful in the treatment of patients with cardiac decompensation who needed corticosteroid therapy for rheumatoid arthritis, since it produced no edema. These findings are substantiated by the present study.

CONCLUSIONS

In contrast to other corticosteroids (*e.g.*, cortisone, hydrocortisone, prednisone, prednisolone and methyl prednisolone)—triamcinolone and dexamethasone seemed to cause very little, or no, retention of sodium or water. In fact, this study shows the converse to be true. In dealing with cardiac and/or hypertensive patients, the clinician may use these newer corticosteroids in treating concomitant and complicating conditions which ordinarily respond to corticosteroid therapy. The present study suggests that triamcinolone produced slightly better results than dexamethasone with slightly less evidence of toxicity or side effects.

SUMMARY

1. Fifty-two patients were treated with triamcinolone or dexamethasone for arthritis complicated by hypertension with or without cardiovascular disturbances. Twenty-seven of these patients received triamcinolone and twenty-five were given dexamethasone. Nine of the fifty-two were in some degree of decompensation.

2. The response to corticosteroid therapy was directly proportional to the duration of the arthritic condition obtaining before therapy was begun.

3. Triamcinolone and dexamethasone were found to be of value in the treatment of arthritis when complicated by hypertension and/or cardiac disease. This was true even in the presence of edema and other evidences of decompensation.

4. Concomitant use of antihypertensive and/or diuretic drugs with triamcinolone or dexamethasone produced a greater diuresis and a more marked fall in blood pressure than the administration of the corticosteroid alone.

5. Triamcinolone seemed to produce slightly better results than dexamethasone but both compounds produced sufficiently good results to warrant their general use.

6. Twenty-one of the 27 patients treated with triamcinolone showed no side effects whatever, whereas only 8 of the 25 receiving dexamethasone reported no toxic reactions or side effects. On this basis, triamcinolone seems to be the drug of choice in the treatment of arthritic conditions complicated by hypertension with or without cardiac disease.

7. The present study covers only short-term therapy with triamcinolone and dexamethasone and the effects of long-term therapy remain to be investigated. Further study of the entire problem should be undertaken in a larger series of patients.

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Bibliography will appear in author's reprints.

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Endocrine Therapy in Malignant Disease*

Worthwhile palliation and prolongation of life can be achieved in a substantial number of cancers of the breast and prostate by endocrine therapy. Corticosteroids are sometimes useful in malignant lymphomata and in the leukemias.

Three broad methods of treatment are available for clinical cancer: surgery, radiation therapy, and chemotherapy. When the cancer is still potentially curable (while it is still limited to the site or organ of origin) surgery or x-ray therapy, alone or in combination, constitute the treatment of choice. However, many cancer patients seek care when they have progressed beyond the potentially curable stage. Furthermore, from one-half to two-thirds of those patients who receive potentially curative surgical or x-ray therapy will develop recurrent disease and present further problems of management. These patients, with primary inoperable cancer or recurrent and disseminated cancer will be candidates for further treatment by chemical methods, including the cytotoxic drugs such as nitrogen mustard and its analogues; the anti-metabolites (of which the anti-folic acid compounds and the purine antagonists are examples); certain antibiotic agents such as the actinomycins; a group of miscellaneous compounds including urethane, the colchicine derivatives, arsenicals, and others; and the steroid hormones including estrogens, androgens, and the adrenocortical hormones and their derivatives.

Endocrine therapy of cancer is an artificially produced alteration in the endocrine environment designed to induce a cessation of growth and/or regression of cancer. Such alterations may be achieved by surgical ablative procedures such as castration (in either sex), adrenalectomy, and hypophysectomy; or through the use of additive hormones such as the sex steroids and cortisone-like drugs. The major area of usefulness for endocrine therapy is in the treatment of disseminated cancers of the breast and prostate, and to a lesser extent, in the leukemias, Hodgkin's disease, lymphosarcoma, and in certain other settings in neoplastic disease.

BREAST CANCER

A. Oophorectomy. Endocrine therapy probably had its beginnings in 1836 with the observations of Cooper [1] that cyclical changes in the growth of primary breast cancer in women occurred in relation to the menses. In 1889, Schnitzinger [2] recorded regression of breast cancer in a woman following castration. Beatson [3] in 1896 cited his experiences in performing bilateral oophorectomy as a means of palliating breast cancer. Subsequently, numerous workers confirmed Beatson's results. In most medical centers today surgical castration is the treatment of choice for pre-menopausal women with recurrent or advanced inoperable breast cancer. In 143 such patients, Treves and Finkbeiner [4] reported an objective remission rate of 44 per cent with remissions lasting approx-

*Presented at the 195th Annual Meeting of The Medical Society of New Jersey, Atlantic City, Section on Clinical Pathology, May 16, 1961.

imately one year. Radiation castration may be considered when oophorectomy is refused; or in poor-risk patients. Oophorectomy in the post-menopausal breast cancer patient has been generally less satisfactory with objective remission rates of 10 per cent or less. That pre-menopausal women with disseminated breast cancer benefit from castration in perhaps 40 to 50 per cent of cases lends evidence to the belief that, in these patients at least, the breast cancer is estrogen dependent. Since however, after a period of some months' duration, tumor activity again begins to progress, efforts to remove remaining sources of endogenous estrogens have been undertaken.

B. Adrenalectomy: In 1951, Huggins and Bergenstal[5] reported remission in women with breast cancer as a result of adrenalectomy. Of those women who had benefited from oophorectomy and then relapsed, about half would again develop an objective remission following bilateral adrenalectomy. That very few of the women who failed to respond to castration developed regressions following adrenalectomy seemed to bear out the premise that adrenalectomy benefited those patients having estrogen dependent tumors. In 1960 Randall[6] reviewed the results of combined oophorectomy and adrenalectomy in a group of post-menopausal women with breast cancer and found remission rates of about 40 per cent. In this group (post-menopausal patients), a vaginal smear showing high estrogenic activity was felt by Finkbeiner[7] to be of some predictive value regarding probability of a favorable response to combined oophorectomy and adrenalectomy. More recently, a preliminary communication[8] from the Committee on Endocrine Ablative Procedures in Disseminated Mammary Carcinoma reported an objective remission rate of 32 per cent in 315 patients in whom adrenalectomy was done and could be evaluated. Survival averaged 22 months for responsive cases compared to seven months for non-responders.

C. Hypophysectomy: During the past decade, endocrine ablative surgery has been extended to the procedure of hypophysectomy.[9] By 1956, Luft and Olivecrona[10] were able to report 22 remissions in 41 breast cancer patients who could be adequately evaluated. In the same year, Ray and Pearson[11] listed 36 remissions in 67 of their hypophysectomized breast cancer patients. In their review of world experience with hypophysectomy in breast cancer, Luft and Olivecrona[10] found a total number of reported remissions amounting to 110 in 197 cases (56 per cent). In 1960 Pearson and Ray[12] were able to cite 343 patients in whom hypophysectomy had been done; these led to 144 remissions, a remission rate of 42 per cent. Subsequently, the Committee on Endocrine Ablative Procedures[8] reported an objective remission rate of 31 per cent in 358 cases. Survival averaged 21 months for responsive cases compared to 6½ months for non-responders.

In the last few years, procedures have been developed in Europe and in the United States for destroying the pituitary gland by means of yttrium-90 implants. Sufficiently large series are not yet available for comparison with standard surgical hypophysectomy.

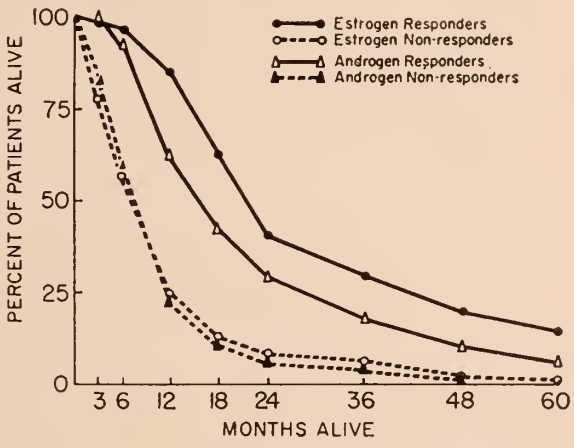
D. Androgens: The measures considered thus far for modifying the course of advanced breast cancer have consisted of the surgical removal of endogenous sources of hormone production. The value of additive hormone therapy in this disease was first demonstrated in 1939 by Loeser[13] and Ulrich[14] who (working independently) reported objective improvements in patients with metastatic breast cancer following the administration of the male hormone, testosterone. These early reports were amply confirmed in subsequent studies. Androgen administration has produced objective remission rates[15] in the order of perhaps 20 to 23 per cent in large series.[17] The standard androgenic preparations which have been most frequently used in breast cancer are listed below:

ANDROGENS	DOSAGE SCHEDULE
Testosterone propionate	100 mg. three times per week intramuscularly
Methyl testosterone	100 mg. daily by mouth
Fluoxymesterone	10 mg. twice daily by mouth

Side effects of the use of androgens in women with breast cancer include the usual signs of virilization including hirsutism, acne, hoarseness, and increased libido. Moderate erythrema has been noted in some, but this is not troublesome. Edema, when present, may be managed with a low sodium diet and diuretics. The mechanism of action of androgens in breast cancer is not known. Theories attempt to account for its action as an antiestrogen, as a pituitary depressant, or through some direct effect on the tumor cell. The problem is complicated by the fact that (at least in some patients) administered androgens can be shown to be converted in the body to estrogens.

E. Estrogens: The value of administered estrogens in breast cancer was first reported by Haddow [16] in 1944. Subsequent workers have confirmed the usefulness of estrogens which, by and large, were tried in post-menopausal women. However, the recent extensive 12-year study of the Subcommittee on Breast and Genital Cancer [17] listed some remissions in pre-menopausal as well as post-menopausal patients. In the combined group of 364 patients adequately treated with estrogens, a tumor regression rate of 37 per cent was reported. In this group, the average survival following estrogen therapy was 27 months in patients who responded, compared with 19 months for those who responded to androgens. Average survival *after* institution of estrogen or androgen therapy in those patients with advanced or recurrent disease who did not respond was nine to ten months, which is approximately the survival expected in the average untreated case. (Figure 1) The estrogenic preparations usually given for metastatic breast cancer are listed below.

Side effects of estrogen therapy include breast enlargement and increased pigmentation of the nipple and areola. Nausea can usually be minimized by starting on a lower dosage schedule and giving the medication after meals. Uterine bleeding, if noticed, is usually controlled by increasing the estrogen dosage. Edema is treated with a low sodium diet and diuretics. On terminating estrogen treatment, withdrawal bleeding may be noted. If severe, oxytocic medications may be given. The mechanism of action for estrogens in breast cancer is speculative. Theories include an anti-



Comparative survival curves of natural post-menopausal patients from initial treatment of metastases.

Figure 1. Reproduced by courtesy of the Editor, J.A.M.A., 172:1271 (March 19, 1960).

androgenic activity, a pituitary depressant effect, and a direct effect on the tumor cell. Estrogens must be used cautiously in breast cancer since, in some patients, the disease may be activated rather than suppressed. For this reason, long-acting estrogenic preparations are not recommended. Clinical and laboratory findings should be observed closely when sex hormone therapy is initiated as hypercalcemia may be produced.

ESTROGENS	DOSAGE SCHEDULE
Diethylstilbestrol	5 mg. three times per day by mouth after meals
Ethinyl estradiol	1 mg. three times per day by mouth after meals
Sodium estrone sulfate	10 mg. three times per day by mouth after meals
Estradiol benzoate	5 mg. three times per week intramuscularly

F. Cortisone: Pearson[18] and associates[19] were the first to cite objective remissions following the use of large doses of cortisone (200 to 400 milligrams per day) in breast cancer patients. They observed a remission rate of 31 per cent with an average duration of remission of three months. Lower dosages of cortisone (50 to 75 milligrams per day) were less effective, with only 14 per cent remissions. Cortisone suppresses the function of the adrenal cortex in man and may well act in this manner in producing some remissions. However, Pearson[18] observed some objective remissions in patients who had previously had oophorectomy and adrenalectomy. In these cases, cortisone must have worked by some other mechanism than suppression of the adrenal function. Since remissions induced by cortisone are usually of short duration, this therapy should be reserved for patients who do not respond to other forms of endocrine therapy or who no longer benefit from such therapy.

COMMENT

THERE is considerable difference of opinion as to the best sequence of endocrine therapy for the breast cancer patient with inoperable or recurrent disease. Most workers in the field agree that oophorectomy (or, as a second choice procedure, radiation castration) should be advised for the pre-menopausal patient. For that group of patients which benefits from castration and later relapses, Pearson,[20] in 1955, advised adrenalectomy as the next approach, followed in succession, as required, by androgens, cortisone, and finally hypophysectomy. More recently, Pearson[21] has suggested that hypophysectomy may be offered as the next procedure after oophorectomy to the patient who benefits and then goes into relapse. For the pre-menopausal patient who derives no benefit from castration, Pearson recommended a trial of cortisone, followed by estrogens and finally by hypophysectomy.[20]

For the post-menopausal patient with primary inoperable or disseminated disease, Pearson[21] advised oophorectomy and adrenalectomy as the initial approach. For those who developed remissions and then went into relapse, he advised androgens followed by cortisone and finally hypophysectomy. For those who did not respond, he recommended in sequence estrogen, cortisone, and possibly hypophysectomy.[20]

Others feel that before adrenalectomy or hypophysectomy is considered, a trial of additive hormone therapy should be made. They reason that, following adrenalectomy or hypophysectomy, patients are unable to meet a stressful situation normally and that, following these procedures, the rate of response to additive hormone therapy is much reduced. For these reasons, they would reserve adrenalectomy and hypophysectomy for patients who fail to obtain remissions with additive hormone therapy or who no longer respond to it.

In *additive hormone therapy*, certain points are worth stressing. An adequate dosage of the hormone should be given for a sufficiently long period of time to constitute a meaningful trial. Objective criteria of regression are the best evidence that additive hormone therapy is of benefit. Criteria include improvement in measurable disease as manifested by decrease in the size of skin metastases, lymph nodes, and primary breast masses as well as improvement in metastatic lung disease and filling in of osteolytic defects in bone. Improvement in blood chemical findings and in the patient's symptomatic state are desirable but do *not*, by themselves, constitute objective evidence of regression by strictest criteria.

The earliest evidence of regression in soft tissue disease rarely occurs before three weeks of therapy. Regression of osseous lesions may take from two to six months to become manifest. It usually requires about three months of therapy to achieve some 90 per cent of the regressions which will be produced by a given hormone.[22] After additive hormone therapy is stopped (because of failure to respond or because of progression of the disease after an initial response to therapy) base line studies,

including chest film, bone survey, serum calcium and alkaline phosphatase, should be obtained and no new therapy initiated, if possible, for at least six to eight weeks. During this time, one may occasionally observe a "rebound regression" in which the patient develops objective signs of improvement following cessation of additive hormone therapy. Kaufman and Escher [23] found nine per cent rebound regressions in patients taken off estrogen therapy and about 3.5 per cent subsequent to the cessation of androgen therapy. In general, a "rebound regression" was more likely to occur in patients who had responded to the hormones prior to their cessation. If there is no rebound regression, the opposite hormone may be tried for its possible effect.

In recent years there has been great interest in synthesizing new steroid hormones by modifying the chemical structure of the basic sex hormone. As an example, a compound having the anti-tumor effect of testosterone but lacking its virilizing effect would obviously be a desirable drug for use in breast cancer in women. A number of such compounds have been advanced. All have fallen short of their original promises. One of the most effective of the testosterone derivatives recently evaluated is two-alpha methyl dihydrotestosterone. This was compared with testosterone propionate in a double blind study by Blackburn [24] and produced 12 responses in 27 trials or 44 per cent objective remissions. While subsequent studies may not confirm this high regression rate, it appeared that virilization with the new compound was less than that expected from testosterone propionate.

Another new compound, delta-one testololactone, has been used by Segaloff,[25] who observed objective remissions in seven of 23 breast cancer patients. While this response rate is in the general range of that seen with true androgens, this compound has thus far demonstrated neither male nor female hormone characteristics by its effects in humans or animals. The search for newer hormone derivatives continues and the field of study of hormone antagonists has just begun.

MALE BREAST CANCER

THE standard treatment for primary operable breast cancer in men, as in women, is radical mastectomy. For primary inoperable or recurrent male breast cancer, castration appears to be the best form of management. Treves [26] observed 24 remissions in 37 such patients. Estrogens have, in general, been disappointing. Androgen therapy may actually be harmful and cause progression of the disease. In a small series of cases, adrenal corticosteroids seem to offer some usefulness. There have also been a few cases of apparent remissions induced by adrenalectomy and hypophysectomy.[26] However, more cases will be required before the value of these procedures can be ascertained.

CANCER OF THE PROSTATE

PROSTATE cancer, by the time it produces symptoms in most patients, has already progressed beyond the stage of curative surgical resection. Less than five per cent of prostate cancer patients are suitable for curative resection in most clinics.[27] However, endocrine therapy has been well established in terms of palliation and prolongation of life. Huggins [28] and associates,[29] in 1941, demonstrated the physiologic dependence of the prostate on androgens and applied castration and the use of estrogens to the treatment of prostate cancer. By 1950, Nesbitt and Baum [30] were able to review 1,818 cases of prostate cancer. They found that (with clinically manifest locally advanced prostate cancer without distant metastases) the five-year survival rate *without* treatment was ten per cent. Treatment with stilbestrol raised the five-year survival figure to 29 per cent; orchiectomy produced a survival rate of 31 per cent; while *with stilbestrol plus orchiectomy, the five-year survival figure was* 44 *per cent!*

In patients with locally advanced carcinoma and distant metastases, the five-year survival rate of the untreated group was six per cent.

With stilbestrol alone, the survival figure was ten per cent. Orchiectomy alone raised the survival figure to 21 per cent while orchiectomy and stilbestrol gave a five-year survival of 20 per cent. Thus, it can be seen that, with locally advanced prostate carcinoma without metastases, either orchiectomy or stilbestrol significantly prolongs survival and a combination of these modalities gives better results than either one alone. When metastases are present at the onset of endocrine therapy, stilbestrol alone does not result in significant prolongation of life nor does it substantially potentiate the benefit which orchiectomy alone produces.

The oral dosage of stilbestrol generally used varies from one to five milligrams daily by mouth in most clinics. If the oral medication is not well tolerated, equivalent amounts of estradiol benzoate or other estrogenic products may be given intramuscularly.

On the theory that reactivation of metastatic prostate cancer, following initial response to orchiectomy and estrogen administration, is due to endogenous production of androgens from the adrenal gland, cortisone has been given [31] in attempts to suppress adrenal androgen production.[32] Although subjective improvement is frequently observed with cortisone, the improvement in symptoms is usually short-lived, and it is difficult to document any objective evidence of tumor regression. The cortisone dosage usually given ranges from 50 to 200 milligrams per day or equivalent amounts of the newer corticosteroids. Whitmore [33] feels that orchiectomy should be the primary treatment in inoperable prostate cancer in that it results in the direct removal of the body's chief source of androgen and avoids, initially at least, the unpleasant feminizing effects of estrogen therapy. If the patient responds to orchiectomy and then develops signs of reactivation, estrogen therapy at this time may induce a further remission. Corticosteroid drugs should probably be reserved for patients who relapse after orchiectomy or estrogen therapy.

Adrenalectomy has been tried by a number of authors [34–40] who, in general, report some subjective improvement, usually specified as relief of bone pain. Remissions are usually of short duration and difficult to document by objective criteria. There have been some reports [41] of favorable results in metastatic prostate cancer following hypophysectomy [42] or intensive irradiation [43] of the hypophysis. However, there are not large enough series available at the present time to recommend this as a routine procedure.

THYROID CANCER

Endocrine therapy of metastatic thyroid cancer has been generally unsatisfactory. It had been hoped that the administration of thyroid-stimulating hormone would enhance the avidity of metastatic lesions for radioactive iodine following ablation of the thyroid gland. In 1955, Rawson [44] produced this effect with TSH in six of 16 patients. However, the effect was transient, possibly due to the development of an antihormone. This has not represented a practical measure in therapy. The administration of thyroid hormone following ablation of the gland has not had impressive results in causing regression of metastases. Nevertheless, its administration is probably indicated to maintain euthyroidism and to inhibit excessive endogenous TSH release which might theoretically accelerate the growth of thyroid cancer metastases.[45]

OTHER MALIGNANT DISEASES

A. Endocrine Ablative Procedures. In diseases other than cancers of the breast and prostate, removal of the gonads or adrenal glands has, in general, been of little or no value in inducing remissions. In their 1956 review of the results of hypophysectomy, Luft *et al.*[8] reported one remission in chorionic epithelioma in four cases operated. They found no remissions to report in malignant melanoma, cancer of the ovary, adrenal, uterus, sarcoma of the breast, or reticulum cell sarcoma. Re-

cently, Ray[43] summarized his experience with 365 hypophysectomies and found the procedure of value only in cancers of the breast, prostate, and possibly the thyroid. He found two cases of apparent benefit in four thyroid cancers reviewed.

B. Sex Hormones. There is no substantial body of evidence at the present time that sex hormones will induce objective remissions in neoplastic diseases other than in the breast or prostate. Kelley and Baker[46] say that large doses of progesterone or other progestational agents produced objective remissions in six of 21 patients with advanced carcinoma of the endometrium.

C. ACTH and Cortisone. These are lymphocytolytic agents, producing a lymphopenia and diminution in size of lymph nodes, the thymus, and spleen in animals. In human neoplastic disease the adrenal corticosteroids have been found of value in acute leukemia, chronic lymphatic leukemia, lymphosarcoma, reticulum cell sarcoma, Hodgkin's disease, and multiple myeloma. In general, remissions induced by these agents are transient and relapse usually occurs promptly when the hormone is withdrawn. Large doses of the hormones are usually required to induce remissions although, at times, once an effect has been achieved, the dosage may often be tapered to lower levels. In general, 100 to 300 milligrams of cortisone per day or the equivalent dosage of the newer derivatives is required to initiate a remission. ACTH probably offers no significant advantages over corticosteroids.

LEUKEMIAS AND LYMPHOMAS

Complete or partial remissions may be induced in at least 50 per cent of cases of *acute leukemia* in children with cortisone-like drugs. The response in adults is not as favorable as it is in children. The remissions last only a few weeks or months, however. It is preferable to initiate treatment with the antimetabolites if the patient is not critically ill when first seen.

A favorable response to corticosteroids may be noted[47] in the majority of patients with *chronic lymphatic leukemia.* Diminution in size of the liver, spleen, and lymph nodes can regularly be achieved; but the drugs must be continued as prompt relapse occurs on cessation of therapy. While other agents can cause remissions equally well in this disease, the corticosteroids are of particular value if hemolytic anemia develops. In addition, the hemorrhagic manifestations of the disease may subside with cortisone administration, even though the platelet count may not return to normal. In contrast to the situation with chronic lymphatic leukemia, the cortisone-like drugs usually are not effective in chronic granulocytic leukemia, and, in fact, may even accelerate the disease.

The corticosteroids can, at times, produce worthwhile remissions in *lymphosarcoma* and *reticulum cell sarcoma.* In general, Hodgkin's disease is less likely to respond to corticosteroids.[48] However, as in chronic lymphatic leukemia, the corticosteroids may be of distinct value in the situation of acquired hemolytic anemia which may develop in the malignant lymphomas.

On occasion, patients with *multiple myeloma* treated with cortisone will develop worthwhile remissions with improvement in well-being and reversal of abnormalities in the plasma proteins. At times, a transient improvement has been noted in patients with spindle-cell sarcoma and other poorly differentiated sarcomas of the soft tissues.[49]

Elevation of the serum calcium has been found to occur spontaneously in metastatic cancer, and as a result of additive hormone therapy. Cortisone administration in dosages of 200 to 400 milligrams daily is effective in many cases in causing a reversal of the hypercalcemia.[50] Apparently, prednisone, in dosages of 60 to 80 milligrams daily, is equally effective as cortisone in this setting.[51]

SUMMARY

ENDOCRINE therapy can result in good palliation and prolongation of life in a substantial number of cases of cancers of the breast and prostate. In addition, the corticosteroid hormones are frequently useful in the leukemias, the malignant lymphomas, and occasionally in other neoplastic diseases. It is to be hoped that, a a result of the intensive investigations under way at the present time, newer synthetic hormone derivatives will become available which will be more effective in cancer patients while causing fewer undesirable side effects. Hormone antagonists have just recently begun to appear and these agents may prove to be of additional value in the treatment of human cancer in the future.

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A bibliographic list of 51 citations appears in the author's reprints.

Oral Polio Vaccine

Oral vaccination trials against poliomyelitis on 6 different groups of Cuban children are described. The first trial demonstrated that carbonated beverages of high acidity were not inhibitory when consumed immediately after the vaccine strains in capsule form. Group two studies showed that the simultaneous administration of all three strains is effective. The result in group three implies that interference between the three strains of poliomyelitis virus is not important when they are given at intervals of seven days in the order: types two, three, one. In the fourth trial the responses were not remarkable. The concurrent influenza observed in some children of group 5 neither influenced the immunization with poliomyelitis virus, nor was it affected by it. The sixth trial resembles the fourth in the population involved, the ages represented, and the history of Salk injections. In the fourth group, in which the capsules were given individually over long intervals (three to five weeks) the conversion rate was 70 per cent. In group six, seven-day intervals were used and the conversion rate was 80 per cent. Eight groups were vaccinated during the past year and all 14 groups comprised about 2,000 patients. The vaccine caused no disturbances. Vaccination during mumps, rubella, and influenza was uneventful. Serum conversion rates from negative to positive varied for the three types of poliomyelitis virus and in the trial groups; the over-all rate was 88 per cent. Booster responses were shown by children whose prefeeding titers were between 1:4 and 1:512. High response rates were obtained when all three strains of virus were administered simultaneously.

—J. Embil, M.D.

Brit. Med. Journ., April 16, 1960.

Smallpox in a Shrinking World

As distances are telescoped by rapid air and sea travel, smallpox epidemics in other parts of the world pose a growing threat to the United States. *The average American has not been vaccinated since schooldays,* according to Surgeon General Burney. "Only 13 of the 49 states require school children to be immunized for smallpox. This widespread lack of immunization would present a serious problem if smallpox were introduced into this country." —*MD,* June, 1959.

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Management of Portal Hypertension*

Do porto-systemic venous shunt operations reduce mortality? Or should the surgeon wait until hemorrhage has occurred? The Walter Reed group in this careful study present figures which support the value of the prophylactic operation.

Cirrhosis of the liver is a matter of continuing concern as this disease steadily rises on the list of the most frequent causes of death in the United States. A large proportion of the deaths are associated with bleeding from esophageal and gastric varices, the consequence of portal hypertension. Portosystemic venous shunt operations for the relief of portal hypertension and the prevention of variceal hemorrhage have been performed for fifteen years and are now the generally accepted treatment if the patient survives his first hemorrhage. This practice has been criticized on the grounds that patients with severe liver disease die of the first hemorrhage, and that those who survive may constitute a "good risk group," not seriously threatened with death by hemorrhage anyway. Operative mortality and postoperative complications are said to constitute a greater hazard to the cirrhotic patient with varices who has never bled than does the threat of fatal hemorrhage.

We wish to contribute some data for the consideration of those engaged in the controversy. We list results in 105 patients treated by portacaval or splenorenal shunt operation at Walter Reed Army Hospital during the last ten years. Ninety-five of the patients had cirrhosis of the liver; 29 of the cirrhotic patients had *not* bled from varices at the time of operation.

MATERIAL

A diagnosis of hepatic cirrhosis was made in 487 patients during the period 1950 through 1959. This was substantiated by examination of the liver at surgery, autopsy, or by biopsy in 331 cases. Esophageal varices were demonstrated by esophagoscopy in 173 of these patients. Ninety-two had bled from varices. A portacaval or splenorenal shunt was done in 62 of the post-hemorrhage patients and

TABLE 1.
HEPATIC CIRRHOSIS PROVED BY TISSUE EXAMINATION, 1950 - 1959

	Unoperated	Operated	Total
With varices	83	90	173
With hemorrhage	(30)	(62)	(92)
Without hemorrhage	(53)	(28)	(81)
No varices	158	—	158
TOTAL	241	90	331

*This paper was read May 17, 1961 at the Section on Gastroenterology and Proctology of the Annual Meeting of The Medical Society of New Jersey. This work is from the Walter Reed Army Hospital in Washington. Colonel Sullivan is a retired Medical Officer; Lieutenant Colonel Cohen and Captain Reynolds are on active duty.

in 28 of the 81 who had never experienced gastro-intestinal bleeding. See Table 1. In the first five months of 1960 portacaval shunts were performed on five additional patients with cirrhosis, varices, and a history of hemorrhage. Shunt operations have been done on ten patients with esophageal varices, normal liver function tests and normal liver biopsies. Nine had experienced one or more massive gastro-intestinal hemorrhages. Cavernous transformation of the portal vein was demonstrated in five of these patients. As indicated in Table 2, age and sex distribution of the prophylactic shunt cases was similar to that of the post-hemorrhage group. Portacaval anastomosis was used in 24 of the 30 operations done prophylactically, and in 64 of the 75 operations done after one or more hemorrhages. See Table 3.

TABLE 2.

AGE OF PATIENTS IN 105 PORTOSYSTEMIC SHUNT OPERATIONS

Age Years	Cirrhosis: Prophylactic Shunt	Cirrhosis: Post-Hemorrhage Shunt	Other Causes
0 - 19	0	4	4
20 - 39	12	26	6
40 - 59	15	33	0
60 - 79	2	3	0
TOTAL	29(6)†	66(16)†	10(1)†

†Number of females in parentheses.

TABLE 3.

PORTOSYSTEMIC SHUNTS

Type of Shunt	Cirrhosis: Alcohol	Cirrhosis: Other	Other Causes	Total
Prophylactic				
Portacaval	17	6	1	24
Splenorenal	1	5	0	6
Post-hemorrhage				
Portacaval	33	26	5	64
Splenorenal	1	6	4	11
TOTAL	52	43	10	105

Considerable attention was given to the pre-operative preparation of the patient. Every effort was made to secure stabilization of the liver disease process, and to attain an adequate nutritional and hematologic state. Levels of serum bilirubin over 3 milligrams per cent and massive ascites refractory to medical management were ordinarily considered contraindications to surgery; but low serum albumin, high Bromsulfalein® retention or abnormal flocculation tests were not so regarded.[3]

Follow-up has been obtained by personal contact in the hospital and out-patient clinic as well as by mail. Only one patient is lost to follow-up.

RESULTS

Deleterious effects of the operation include: (a) the operative mortality; (b) deaths after the immediate postoperative period; (c) non-fatal complications; and (d) any adverse effect upon length of life. Severe hepatic cirrhosis was the most important determinant in each of these elements, and was present in comparable degree in both the prophylactic and the post-hemorrhage shunt patients, but absent in the non-cirrhotic group. The unoperated cirrhotic patients treated in the hospital at the same time unfortunately would not constitute a valid control group.

Operative mortality in the prophylactic shunt group was 3.4 percent (one death); and in the post-hemorrhage shunt group 10.6 per cent (seven deaths). There were no deaths in the non-cirrhotic group. The fatal prophylactic shunt case was in a woman with post-necrotic cirrhosis and ascites who died in liver coma eight days after surgery. Four of the post-hemorrhage shunt deaths were in patients operated upon as an emergency to stop bleeding which could not be controlled by tamponade; two were patients with serious strictures of the common bile duct, and one had severe ascites not controlled by prolonged medical treatment.

Post-shunt complications were noted in 28 per cent of the prophylactic shunt group, 52 per cent of the post-hemorrhage group, and 40 per cent of the non-cirrhotic group. See Table 4. Hemorrhage from varices occurred in two of the prophylactic shunt patients (7 per cent); one required no transfusion, but it was necessary to ligate the varices in a 71-year old man with a hepatoma. Twelve post-

TABLE 4.

POST-SHUNT COMPLICATIONS

	Prophylactic 29 Patients		Post-hemorrhage 66 Patients		No Cirrhosis 10 Patients	
	No.	%	No.	%	No.	%
Varix hemorrhage	2	7	12	18	4	40
Mental symptoms	4	14	13	20	0	0
Jaundice, ascites, etc.	5	17	15	23	0	0
None	21	72	32	48	6	60

TABLE 5.

DEATHS AFTER PORTOSYSTEMIC SHUNT
95 CIRRHOTIC PATIENTS

	Prophylactic Shunt		Post-hemorrhage Shunt	
Cause	No.	Per Cent	No.	Per Cent
Postoperative	1	3.4	7	10.6
Liver failure	7	24	11	16.6
Varix hemorrhage	0	0	6	9.9
Ulcer hemorrhage	2	7	3	4.5
Unrelated	2	7	5	7.5
TOTAL	12	41.4	32	48.5

hemorrhage shunt patients (18 per cent) bled from varices after operation; additional surgery was performed in three patients, but was not required in three others. Hemorrhage was only an additional manifestation of severe, progressive, terminal liver failure in the remaining six patients. In the non-cirrhotic group four patients (40 per cent) bled after operation and two of these were operated upon again. There were no other complications in this group of cases.

Mental confusion, precoma or coma was reported in four of the prophylactic shunt patients (14 per cent). It was intermittent, mild, and required drug therapy in only one case. Thirteen of the post-hemorrhage shunt patients (20 per cent) exhibited this complication; in ten of them it was associated with other manifestations of terminal liver failure. Jaundice, ascites or other evidence of liver failure was found in five prophylactic shunt patients (17 per cent) and in 15 post-hemorrhage shunt patients (23 per cent). The most significant feature of this analysis is that 72 per cent of the prophylactic shunt patients, 48 per cent of the post-hemorrhage, and 60 per cent of the non-cirrhotic patients were free of all these complications.

As shown in Table 5, the most frequent *cause of death* in the cirrhotic patients was liver failure. This accounted for seven deaths (24 per cent) in the prophylactic shunt group and included two who died of hepatoma. There were 11 deaths from liver failure without associated hemorrhage in the post-hemorrhage group (17 per cent). No deaths were associated with bleeding varices in the prophylactic group, but six patients (10 per cent) of the post-hemorrhage group had massive hemorrhage as a feature of terminal liver failure. None of these patients died of exsanguination. In no case was the hemorrhage the precipitating factor in the initiation of the terminal liver failure. Hemorrhage from duodenal ulcer and deaths from unrelated causes occurred with about equal frequency in the two groups.

The *survival rate*, calculated by the actuarial method of Berkson and Gage [2] (and including the postoperative deaths) shows little difference between the prophylactic shunt group and the post-hemorrhage group for the first two years but gives a somewhat more favorable rate to the former as the number of years after operation increases. The survival rates at the end of two years, four years, and six years after operation are 70, 65, and 52 per cent for the post-hemorrage shunt cases. There was only one death in the non-cirrhotic group. The number of cases was too small to permit meaningful comparison by this method.

COMMENT

Portosystemic shunts seem to be effective in preventing fatal hemorrhage. No death was associated with hemorrhage in the prophylactic shunt group and no deaths were attributed to hemorrhage in the post-hemorrhage group. The operations have not entirely prevented subsequent bleeding from esophageal varices, however. In a few instances the

shunt failed because of thrombosis; on other occasions the diameter of the vessels used in the anastomosis was too small to permit the blood flow required to reduce portal pressure to normal. In still other instances, the shunt seemed patent and adequate in size, the portal pressure was only moderately elevated, and the reason for bleeding remained unexplained. We have a definite prejudice against the splenorenal shunt: 39 per cent of our patients bled after this operation while only 12 patients (13.6 per cent) of the portacaval shunt group bled after surgery. Two of these were patients with portal veins of insufficient caliber (7 millimeters diameter) and two were patients with cavernous transformation of the portal vein in whom the shunt was constructed with a thin-walled, collateral vessel of doubtful integrity.

It is our impression that there was little difference in the severity of the disease process in the two groups of cirrhotic patients. The various causes of death occurred with similar frequency in the two groups. The difference in outcome was somewhat fewer complications and a somewhat greater survival rate in the prophylactic shunt group. Cirrhosis of the liver is a dynamic disease of great variability; it is not possible with the data available to us to quantitate any differences in hepatic reserve in the two groups. We cannot prove that the better showing of the prophylactic shunt group was due to the absence of massive hemorrhage. We would think that if any benefit accrued from the operation it would be represented in the number of patients who were protected from a fatal initial hemorrhage. There is no way of knowing exactly how many of these 29 cirrhotic patients with esophageal varices would have experienced such an event without our in-

TABLE 6A.

SURVIVAL RATES OF CIRRHOTIC PATIENTS
POST-HEMORRHAGE SHUNTS

(7 Postoperative Deaths Included)

Years Since Oper.	Last Report Dead	Last Report Alive	Living Beginning Of Interval	Person Years Exposed	Probability of Dying in Interval	% Survival to End of Period
0 - 1	13	8	66	62	.210	79.0
1 - 2	6	4	45	43	.139	68.0
2 - 3	5	7	35	31.5	.159	57.2
3 - 4	3	1	23	22.5	.133	49.6
4 - 5	4	1	19	18.5	.210	38.9
5 - 6	0	3	14	12.5	——	38.9
6 -10	1	10	11	——	——	——
	—	—				
	32	34				

TABLE 6B.

PROPHYLACTIC SHUNTS

(1 Postoperative Death Included)

Years Since Oper.	Last Report Dead	Last Report Alive	Living Beginning Of Interval	Person Years Exposed	Probability of Dying in Interval	% Survival to End of Period
0 - 1	4	3	29	27.5	.145	85.5
1 - 2	4	1	22	21.5	.186	69.6
2 - 3	1	4	17	15	.066	65.0
3 - 4	0	1	12	11.5	—	65.0
4 - 5	2	2	11	10	.200	52.0
5 - 6	0	2	7	6	—	52.0
6 - 8	1	4	5	3.5	.286	37.1
	—	—				
	12	17				

tervention. A valid control group of entirely similar but unoperated patients is not available for comparison. Baker, Smith and Lieberman[1] have reported on 115 cirrhotic patients who had never bled at the time esophageal varices were discovered and who were not treated surgically. Thirty-three (29 per cent) patients subsequently bled; 20 exsanguinated, seven died in hepatic failure, four died of unrelated causes and two were alive at the end of the study. The number who died of liver failure was 31 (26 per cent), very close to our results. Eleven (9.5 per cent) died of exsanguination during the first episode of hemorrhage. If these patients were considered to be comparable with our groups, the advantage of prophylactic portacaval shunts would be proved. Since the identity of the groups has not been established, we must be more cautious in our statements.

We conclude that portosystemic venous shunt operations can be done in patients with cirrhosis and esophageal varices with an acceptable operative mortality and without an undue incidence of complications. We find that the actuarial survival rate is more favorable in patients operated upon before hemorrhage has occurred. It is assumed, but not proved, that some fatal hemorrhages are prevented by prophylactic portacaval shunt operations. We recommend that cirrhotic patients with portal hypertension and esophageal varices be sought out so that appropriate therapy can be given before hemorrhage occurs.

SUMMARY

1. Portosystemic venous shunts were done in 105 patients, 95 of them cirrhotics. All had esophageal varices but 29 of the cirrhotics and one non-cirrhotic patient had not bled before operation.

2. The operative mortality in the cirrhotic prophylactic shunt group was 3.4 per cent; for the post-hemorrhage cirrhotic group 10.6 per cent; and zero for the non-cirrhotic group. No deaths were associated with hemorrhage in the prophylactic shunt group, but six in the post-hemorrhage shunt group bled during the terminal episode of liver failure. Eleven other patients in this group died of liver failure, a total of 26 percent for the post-hemorrage group. Deaths from liver failure occurred in 24 per cent of the prophylactic shunt group.

3. Actuarial survival rate at the end of two, four and six years for the prophylactic shunt group was 70, 65 and 52 per cent; for the post-hemorrhage shunt group 68, 50 and 39 per cent.

4. No entirely suitable control group of unoperated patients exists for comparison. In a published series of cirrhotic patients with varices but no history of bleeding, and who were *not* subsequently operated upon, hemorrhage occurred in 28.6 per cent; 17.3 per cent exsanguinated, 9.5 per cent with the first hemorrhage. Twenty-six per cent died of liver failure. It is our belief that prophylactic shunt operations have prevented some fatal hemorrhage in our patients.

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Irvington

Medical Aspects of Air Pollution*

Air may be free; but it may also be dangerous. In a sense, we are all drowning in a sea of polluted air. Dr. Paul here points up the problem and suggests a few common-sense solutions.

In the past few decades air pollution has been receiving attention as a major public health problem. Only since the beginning of the industrial revolution in the late eighteenth century (with the increased use of fossil fuels) has air pollution assumed major importance. It was first considered a nuisance affecting chiefly industrial areas and the surrounding homes of the working people. With the later increase in industrialization and urbanization and with the introduction first of steam railroads and then of other types of mechanized transportation, larger areas were affected and economic losses due to it became significant. House paint became stained, drying laundry was dirtied, exposed metal corroded, vegetation blighted, and airports shut down. At times, under adverse weather and industrial conditions, people became aware of burning eyes and irritative coughs. It was soon apparent that there was a health aspect to the problem. In some densely populated industrial cities where certain fuels like soft coal were used and where geographic and meteorologic conditions were not favorable for the removal of accumulated pollution into the large reservoir of surrounding air, a demand that something be done arose from the long suffering public. Some cities, like Pittsburgh, that in the early years of the century had a reputation for bad air conditions have been successful in improving them.

Since World War II, with the recent great expansion of the American economy, air pollution has become a country wide concern. Our population is increasing and is concentrating in large urban areas; industrial production is expanding at an even greater rate; the number of cars on the highways is greater; but the atmospheric reservoir in which we have been diluting our wastes is the same.

Because of these widespread social, economic and health factors, all educated citizens should become informed about this. Because of its serious health aspects, the medical profession should study it and cooperate with engineering, scientific and governmental groups to help find a satisfactory solution.

Acute Effects of Polluted Air

Although some of the acute disasters caused by the contamination of the atmosphere have been given wide publicity it may be of interest to mention three dramatic instances to recall how horrible and how unexpected the results may be. In December 1930, a fog settled down on a heavily industrialized part of the Meuse Valley in Belgium. This was at a time of thermal inversion; a condition in which the temperature of the upper air is

*Read May 17, 1961 before the joint assembly of the Chest Diseases and Allergy Sections of The Medical Society of New Jersey.

warmer than that of the lower air. By a static balancing of the physical forces described by the gas laws, this upper layer of air acts as a lid on the community, preventing diffusion of the contaminated air. In this Meuse Valley episode, in three days 6000 people became ill and 60 died.

In October 1948 a dense fog settled over Donora, Pennsylvania. This town is in a bend of the Monongahela River, surrounded by high hills on all sides. A thermal inversion was present. In a few days 5910 people (43 per cent of the population!) became ill and 19 died. Both the Meuse Valley and Donora epidemics stopped abruptly with the appearance of rain and air motion.

London has, in a way, recognized an air pollution problem for centuries. Even before the Hundred Years War, a Royal Proclamation prohibited the use of sea coal in London fireplaces. This prohibition was again proclaimed in Shakespeare's day 250 years later. Not too much attention was paid to either proclamation. The industrial revolution had its first flowering in England. In 1808 William Blake referred to the "dark Satanic mills" in his poem "Milton." Today in England and Wales 49 million people live in an area of 58 thousand square miles, approximately that of the states of New York and New Jersey combined. In this small area, 200 million tons of soft coal are burned annually. Consequently, the air pollution problem has become extremely serious. There have been repeated epidemic episodes, a particularly dramatic one occurring in London in the week of December 5, 1952. Again the meteorologic factors were fog and thermal inversion. Many people became sick. Exact morbidity statistics are lacking, but there was an excess of 4000 deaths above the expected mortality for that week.

CHRONIC EFFECTS OF POLLUTED AIR

IN THESE acute episodes of sudden smog there is no doubt of the relationship of the air contamination and the increase in morbidity and mortality. It is more difficult to establish a correlation between lower concentrations of air pollutants and illness and death. Epidemiologic and laboratory studies of this problem are in progress and will in time give some definite information. The present interest in the study of lung physiology (including emphysema and the widening of the concept of lung failure) will add to our knowledge of the deterioration of the lung tissues with various environmental exposures as well as with age. In the meantime we must interpolate and extrapolate from data now available. We know that workmen exposed to silicon dioxide and some other dusts over long periods of time have impaired lung function due to fibrotic proliferation of the pulmonary tissues. Persons *without* occupational exposure to dusts (who have spent all or a large part of their lives in cities) give gross evidence at autopsy of the presence of foreign matter in their lungs by the dark color of these organs and by the color and consistency of the hilar glands. We have become aware of the correlation between cigaret smoking (which has been called a personal air pollution) and lung cancer and other diseases. In Los Angeles, when patients with marked emphysematous lung failure are placed in air conditioned rooms with filtered air, their lung function improves promptly. Allergists report that their asthmatic patients have more attacks during smog episodes than when the atmosphere is clear.

CONTROL OF POLLUTION

CONSIDERATIONS such as these concerning health re-enforce esthetic and economic considerations and give sufficient reason to lower the pollution level as much as possible at the present time. We cannot afford to wait until all epidemiologic and experimental studies have been completed as the sources of contamination are increasing all the time.

Air pollution control is properly a governmental function. The public agency in charge of this control program must be objective and

its policy set by well informed professional people. It must be realistic since in an industrial society, air pollution cannot be entirely eliminated. Reasonable standards of control should be set and maintained. The agency should depend largely on voluntary action achieved by education of legislators, industrialists, apartment house owners and other large contributors to air contamination. The education of the average citizen should not be neglected. He can help by keeping his car and heating equipment in good repair, by not burning leaves and in many other ways. But as voluntary cooperation will have its limits, especially when it is in conflict with economic interests, the agency or Commission should have legal power and sufficient personnel to enforce a reasonable and fair code.

The physician with his special training can contribute much to the study and evaluation of the air pollution problem and in cooperation with scientific, engineering, industrial and governmental administrative groups can help in finding a satisfactory solution.

788 Lyons Avenue

The Temporal Bone Bank

John F. Daly, M.D. (Professor of Otolaryngology at the N. Y. University Medical Center) has said that the current temporal bank program "will be singled out as one of the most progressive steps taken in the development of research in deafness.

You can get more details from the Deafness Research Foundation at 310 Lexington Avenue, New York 16, N. Y. Included on the National Committee of this foundation are two New Jersey physicians: Dr. Walter Petryshyn of Montclair and Dr. Lyndon Peer of East Orange.

The Deafness Research Foundation (organized in 1958) is the only national voluntary organization devoted to the support of investigation into the causes and cure of impaired hearing. Vigorous steps are being taken to provide funds for research into this problem which tragically handicaps its victims in their jobs, in their family relationships, and in every human activity dependent upon the precious gift of communication.

One serious handicap is the fact that the inner ear cannot be examined directly during life. Determination of the exact nature of the disease which caused the disability can be made only after death by removal and preparation for microscopic examination of the temporal bones. Because deafness rarely causes death, it may be a lifetime before the inner ears of the child who could not learn to speak can be examined completely.

A further obstacle has been the difficulty of obtaining the temporal bones of persons whose deafness has been medically documented during life. To be of greatest value to research, it is necessary that periodic examinations shall have been made by an otologist, and that the history and records of findings are available.

The Temporal Bone Bank's program has been established to provide a channel through which individuals may bequeath their temporal bones to science. In laboratories throughout the country, inner ear findings will be correlated with the patient's history and records. This will determine pathological conditions that accompany deafness. In addition, the effects of previous medical or surgical treatment will be evaluated. Information provided by this research will also be made accessible to trainees in otolaryngology and will be used to help train laboratory technicians.

Another reason for acquiring the middle and inner ear structures is to implement surgical training of specialists. Ear surgery is often done with the operating microscope. Considerable skill and training are required to manipulate instruments in the narrow confines of the middle ear even with magnification. Such skill can be acquired only by practice on human ear structures. The temporal bones of persons with no history of hearing impairment can therefore also be of value in the training of otologists.

B. N. Grabelle, M.D.

Eatontown

Antitussive Therapy with Pholcodine

If Dr. Grabelle's results are confirmed by others, we would appear to have here a swiftly effective cough control. It must be remembered, however, that pholcodine is a morpho-morphine.

Coughing is a protective reflex designed to expel irritating inflammatory exudation or foreign bodies from the respiratory tract. A non-productive cough, however, is incapable of eliminating the irritating factor and acts only as an increasing source of irritation.[1]

A non-productive cough should be controlled, whether it is caused by inflammation, foreign particles, pressure on the trachea, stimulation of the vagus nerve in the external auditory canal,[2] circulatory disturbances[3] or changes in the respiratory system. Even a productive cough, if it becomes excessive, must be controlled because of its potential danger and general debilitating effect.[4]

Few antitussive agents are specific, effective and free of side reactions. The most commonly prescribed are the narcotic antitussives. Though these are considered effective and have achieved wide acceptance, they pose the problems common to all narcotics, including clouding of the sensorium, gastro-intestinal spasticity and constipation. Indeed, the opium alkaloids[5] have been used as the classic treatment for the relief of hyperperistalsis.[6]

This study reports on the clinical testing of a new antitussive agent, an ether oxide phenanthrene derivative of morphine. This is morpho-linyl-ethyl morphine, also known as pholcodine. Though more potent than codeine on a weight basis,[7] it is considerably less toxic.[8] It has been described as possessing the marked advantages of negligible, if any addiction liability,[9] of being non-constipating,[10] and devoid of systemic analgesic action, and of producing no effect on the sensorium.[12] Thus, it appears to act almost specifically as an antitussive agent and seems almost completely free of the undesirable side effects induced by the other commonly used agents for the control of cough.

Methods and Materials

The drug was studied in a series of 53 patients, seven of whom were children between the ages of 3 and 12 years. Forty-one of the 53 patients had acute coughs; 12 had chronic coughs. Of the acute, four were classified severe, 21 as moderate and 16 as mild; of the chronic, two were severe, five moderate and five mild.

Twenty-four patients had coughs associated with upper respiratory infections; 10 with bronchitis; three with influenza; and two with asthma. Six had chronic, dry coughs. Eight had coughs of other and varied causes.

Although no patient received an antitussive agent in addition to the pholcodine, 28 did receive concurrent medication directed at the underlying pathology.

The pholcodine was available either in tablet or liquid form.* One tablet contains 5 milligrams of morpho-linyl-ethyl morphine. A teaspoonful of the liquid carries 5 milligrams of pholcodine. The patient's preference determined the form used. The program was to give one or two tablets every four hours over the period of treatment, depending on the severity and nature of the cough and the age of the patient.

The effectiveness of pholcodine as an antitussive was evaluated according to the following criteria:

Excellent—when complete relief was secured within 48 hours after initiation of therapy

Fair—when moderate relief was evident in 24 to 48 hours

Poor—when minimal or no relief was obtained within the first 48 hours

A general questionnaire covered the subjective reaction of the patient to the drug as compared to previous forms of antitussive therapy. His "acceptance" of the medication was also considered. Side reactions, including constipation and changes in the sensorium were carefully checked.

RESULTS

THE table summarizes the results obtained with pholcodine. Good to excellent results were obtained in 49 patients (93 per cent) and poor results in 4 patients, or 7 per cent. Fifty-two of the 53 patients showed no sign of disturbance of the sensorium. No instance of complicating constipation occurred, and no other side reactions were observed.

Patients	Severity of Cough	Effectiveness of Pholcodine: Excellent	Good	Poor	Per Cent With Poor Results
6	Severe	3	2	1	16.0
26	Moderate	14	11	1	4.0
21	Mild	10	9	2	10.0
53	Totals	27	22	4	

*Kindly supplied by the Medical Department of the Purdue Frederick Company of New York City.

The subjective response of a significant number of patients indicated that, compared to previous forms of antitussive therapy, "greater satisfactory relief was obtained with pholcodine." Patient acceptance of the drug, in both liquid and tablet form, was excellent.

COMMENT

ALTHOUGH the narcotic antitussives are considered the most effective agents in the suppression of coughs, their mode of action is not generally regarded as desirable. Investigators[9] have suggested a direct central action for these narcotics and have pointed out that they have a definite influence on the pattern of respiration. May and Widdicombe[10] have demonstrated differences in cough-respiratory correlations among the truly narcotic antitussives and pholcodine. Pholcodine affects respiration less than codeine, morphine or pentobarbital. Unlike the two latter drugs, it seems to act by blocking the expiratory phase of cough rather than the inspiratory.[10]

Codeine, which depresses both phases of the reflex, requires larger doses for effective action. This action, however, is accompanied (in the natural opium alkaloids and the synthetic, related compounds) by disturbing side reactions[6] including respiratory depression, possible addiction, constipation, effects on the sensorium and generalized toxicity.[11]

Pholcodine, in the present study, showed a high degree of therapeutic effectiveness in both acute and chronic cough, whether severe, moderate or mild. Side reactions were virtually non-existent. Reports from the literature[1,7] indicate that this absence of side reactions is characteristic of pholcodine.

Long-term use of pholcodine has shown no addiction. The World Health Organization's Expert Committee on "Drugs Liable to Prove Addictive" found pholcodine a relatively, and possibly *completely non-addictive drug*.[12] The absence of gastro-intestinal and central nervous system side effects as well as any systemic toxicity in this study is in complete confirmation of previous reports to this effect.

SUMMARY AND CONCLUSIONS

1. The antitussive effects of pholcodine have been evaluated in 53 patients, 41 with acute and 12 with chronic coughs. The coughs were due to a variety of factors, including upper respiratory infections, bronchitis, influenza and asthma.
2. Pholcodine produced an excellent or good result in the control of cough in 49 of the 53 patients; poor results were obtained in four.
3. Unlike the commonly used narcotic antitussive agents, administration of pholcodine was not accompanied by a single instance of constipation. Clouding of the sensorium was virtually absent and no other side effects were observed. Patient acceptance of the drug in either tablet or syrup form was excellent.
4. Pholcodine would appear to be an effective and almost specific antitussive agent virtually devoid of undesirable side effects.

350 Broad Street

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Are Staff Doctors Exploited?

The hospital resident should receive reasonable pay for the many services he performs.

An editorial in the April 1961 *New Physician*, journal of the Student American Medical Association, says: "The fact is that residents perform numerous hospital services which directly or indirectly account for substantial income to the hospital. The hospital as a charitable institution is the deserving recipient for charitable contributions, but our system of providing hospital care should not force the resident, who so frequently is not entirely self-sustaining, to be an unwilling contributor."

Since many hospital administrators seem unwilling to end this economic exploitation of medical training, the suggestion was made, "to charge each patient a flat rate, for example, $1 per day, for 'Routine House Staff Services.' Such charges should be used exclusively for the purpose for which they are collected."

"It may be an over-simplification, but it is nevertheless a basic truth that the added cost of reasonable stipends to interns and residents should be borne by the same people who pay for the brick and mortar, hospital beds, nurses, technicians, and cooks' wages."

The editorial concluded, "With a diminishing number of the best qualified students embarking upon medical careers, it is imperative that immediate measures be taken to minimize the years of financial sacrifice following graduation."

Bertram M. Kummel, M.D.

Morristown

Orthopedic Management of Marie-Strumpell's Disease*

In his approach to Marie-Strümpell's disease, Dr. Kummel emphasizes the conservative or non-surgical orientation. The role of appliances and the technic of exercises are discussed.

When a physician undertakes the treatment of ankylosing spondylitis, he must be prepared to recommend all indicated modes of treatment, or to request consultation by appropriate specialists to obtain the best therapy in the particular case. I personally tend to emphasize the orthopedic modes of treatment, but I do utilize medication and even radiotherapy after consultation. From the orthopedic standpoint, conservatism is the key to treatment. The simplest measures are often the most effective and hinder the patient the least.

Throughout this paper, various modes of treatment are labelled as "aids" in the prevention of deformity. This goal is just as important as relieving pain or returning the patient to work. Even in periods when the disease is inactive, proper posture, seating, and extension exercises have to be pursued. The disease burns itself out sooner or later. The disability thereafter depends on deformity. All of us have seen people fused from head to pelvis who managed well. Others who cannot stand erect have a great deal of disability.

In the *acute inflammatory stage,* utilize bed rest and traction. Where the disease involves the lumbar and lower dorsal regions, pelvic traction in a slightly "Fowler" position often gives excellent relief. Cervical traction is effective in upper dorsal and cervical lesions. If motion causes no acute pain, exercises should be performed. Heat, and light massage, expertly given, are often helpful in this stage.

EXERCISES

As soon as the patient can tolerate exercises, these should be begun, and should be active only. During the more quiescent stages, resistance can be applied. When inflammation and pain have begun to subside, knee to chest exercises in bed are, possibly, the first that can be started and well tolerated. Later, abdominal and back extensor exercises are done. Emphasize dorso-lumbar extension to prevent the frequent deformities that develop in this disease. When cervical and upper dorsal spines are involved, range of motion exercises, with particular emphasis upon extension, should be advised. For shoulder and hip joint involvement, again movements of an active nature should be performed daily to tolerance, to maintain maximal motion. Flexion of the hip joints is prone to develop early, and emphasis on extensor power is required. These exercises are best done in the prone position.

APPLIANCES

In the ambulatory patients whose complaints do not require bed rest and medication, bracing is often of great assistance in relieving pain. These appliances can help prevent de-

*Read before the joint assembly, Sections on Rheumatism and Orthopedics of The Medical Society of New Jersey, May 16, 1961.

formity. In the lumbar region, one of the three-point extension devices is often indicated. I have no personal preference for the Jewett brace or other types. The device must be comfortable and fit well. Often a simple plastic collar will help with neck problems. Occasionally, a more formal brace (such as the four-poster or a leather or plastic mold) is necessary. When appliances are used, exercise becomes even more important, as there is a greater tendency toward atrophy.

Intermittent traction is valuable in maintaining the patient in an ambulatory and working condition. The use of pelvic traction at home at night often means the difference between a good night's rest and none. Intermittent cervical traction (such as the commercial set which clamps on a door) is even more successful in aiding the patient who has involvement of the neck.

Some say that traction can correct deformity in a spine ankylosed by bone. It is true that deformity in the joints united by fibrous ankylosis can be favorably influenced by conservative measures; but only osteotomy can change a fused joint. The process of spontaneous fusion may skip one or more joints and proceed at a higher level. Often x-rays taken in two planes, with or without good technic, will disguise the lack of bony ankylosis.

A simple device (such as crutches) will often relieve the back of strain and tend to minimize pain. A cane is often of value in protecting a damaged hip from constant wear and tear in walking. It has been calculated that a walking stick in one hand can reduce the stress on the opposite hip by 50 per cent.

SURGERY

I HAVE had little experience with the radical approach to the problem of deformity following Marie Strümpell's disease. I am happy that I have had very little experience with it. The correction of spinal deformities, both lumbar and cervical, has been done successfully. However, the literature is replete with warnings concerning paraplegia and even sudden death as a result of these manipulations. It goes without saying, that the best approach is prevention of the development of deformities which require spinal osteotomy. In this day and age, such deformities should not occur. *Spinal fusion has no place in the treatment of this disease.*

In hip involvement, femoral osteotomy has an important place; particularly with reference to patients who have hip flexion deformity unilaterally with lumbar flexion. Other hip cases which respond insufficiently to conservative treatment may require cup arthroplasty or other types of prostheses. Due to my very limited experience, I am unable to comment on these.

Fusion is contra-indicated as the opposite hip may be involved at any time. The theory of fusing one hip and doing an arthroplasty on the other is excellent; but only in theory.

A word remains to be said concerning spontaneous bony ankylosis of the sterno-clavicular and acromio-clavicular joints. These joints are not frequently involved in this disease, but occasionally they can be troublesome. Here surgery is indicated early, because of its success. Simple resection of the inner end of the clavicle when the sternal joint is involved, or similar resection of the outer end of the clavicle for the acromial joint will restore motion and relieve pain.

CONCLUSION

THIS has been a brief outline of the orthopedic treatment of this disease. The approach should be very conservative, with emphasis on exercise and prevention of deformity. Surgery is very much of a last resort in the cases of spinal deformity. In the hip, it leaves much to be desired. For the rare cases of clavicular joint involvement, resection can be quite satisfactory.

290 Madison Avenue

Trustees' Meeting: July 16, 1961

The Board of Trustees met in Trenton on July 16, 1961. Among actions taken were the following:

At the request of the President, the 1961-2 list of Special Liaison representatives and special committees* was approved.

A letter was read from Duane E. Minard, Jr., president of Hospital Service Plan of New Jersey, giving assurance that HSP has initiated a study to determine the extent of possible cost of liberalization of the Blue Cross contract with respect to limitation as to maternity services, and promising that when the HSP findings are definite the position of HSP will be transmitted to The Medical Society of New Jersey.

Also read was a letter addressed to the Secretary of the Essex County Medical Society, from C. H. William Ruhe, M.D., Assistant Secretary to the Council on Medical Education and Hospitals of the AMA. The letter states:

> According to our records the Kansas City University of Physicians and Surgeons in Kansas City, Missouri was *not* an accredited medical school in 1943. To the best of my knowledge this school was never a formally accredited school.
>
> The only medical school in Kansas City which has ever been formally accredited is the University of Kansas Medical School in Kansas City, Kansas. This school has been formally accredited since 1913.

The Board directed that a copy of Dr. Ruhe's letter, or its essential content, be transmitted to secretaries of all component societies; together with the promised explanation of the significance and impact upon the processing of membership applications of the decision of the Superior Court in the case of Falcone *vs.* Middlesex County Medical Society. When these materials are available for transmittal to the component societies, they will be reflected for the information of the general membership in the *Membership News Letter*.

The Treasurer reported a notice of credit to the account of The Medical Society of New Jersey (General Account) of $40,000, representing proceeds from redemption of securities held in custody by the Chase Manhattan Bank. Also reported was the purchase of securities for the account of The Medical Society of New Jersey in the total amount of $120,000. The report of the Treasurer was approved.

Mr. Nevin reported that the New Jersey Funeral Directors' Association asked the assistance of the Society in achieving the cooperation of the members of The Medical Society of New Jersey in the prompt completion of death certificates so that (in conformity with the laws of New Jersey) there may be no undue delay in the funeral directors' moving and interring bodies. The Board approved this request.

The John Hancock Mutual Life Insurance Company reported that the Bergen County Medical Society had established a disputed bills committee to deal with matters brought before it by insurance companies. In a conference at the Bergen County Medical Society, reference was made to the proposed New Jersey *Relative Value Index*. Request was made for a copy of the Index to the end that (although it is recognized as not having been officially adopted) the *Index* might be used as a guide in passing upon the acceptability of professional fees for services to patients covered by insurance companies.

In meetings with the Health Insurance Council, the Society had made it clear that it would *not* approve the establishment by component societies of special committees to deal with disputed bills presented by insurance companies. We regard the judicial mechanism as the proper agency through which such complaints should be processed. Under the Bylaws of The Medical Society of New Jersey, judicial committees of component societies are specifically charged with the responsibility of dealing with complaints, from any source, involving fees.

A *Relative Value Index* for New Jersey is, at present, only being contemplated. If ultimately such *Index* is adopted it will be for the reference of the judicial mechanism in disposing of complaints involving fees. It is *not* intended to serve as an instrument for use by other agencies to set fees for physicians. The Board directed, therefore, that the request of the John Hancock Mutual Life Insurance Company for a copy of the proposed Relative Value

*See page 572 this JOURNAL.

Index for New Jersey be denied for the reasons set forth. The Board further directed that a copy of the communication to the John Hancock Insurance Company be sent to the secretaries of all component societies, and to the chairman of the conference group from the insurance industry to the Health Insurance Council.

Announcement was received from the AMA concerning the Institute, to be held in Chicago, August 31 and September 1, 1961. The Board authorized that, upon receipt of the proposed program for the Institute, at his discretion the President designate the representatives to attend, suggesting that he consider himself, the President-Elect, and the Executive Officer.

RELATIONS WITH OSTEOPATHS

In behalf of the Judicial Council, Dr. Patterson—Councilor from the Fifth District—presented the following opinion, adopted by the Judicial Council at its meeting on July 12, 1961:

Whereas, recent action by the Joint Commission on Accreditation of Hospitals indicates that the presence on hospital medical staffs of doctors of osteopathy having full licenses as physicians and surgeons will not jeopardize *per se* accreditation of such hospitals; and

Whereas, in a recent opinion ordering one of the component societies of The Medical Society of New Jersey to accept an osteopathic physician as an active member, the Supreme Court of New Jersey declared that any graduate of an osteopathic school approved by the New Jersey State Board of Medical Examiners has received "a full course in Medicine"; and

Whereas, the Judicial Council of The Medical Society of New Jersey, in conformity with the action of the House of Delegates of the American Medical Association and in support of the code of ethics of the American Medical Association, has heretofore ruled that any voluntary professional association between doctors of medicine and doctors of osteopathy is unethical; and

Whereas, the House of Delegates of the American Medical Association at its 1961 Annual Meeting ruled that policy regarding relationships of doctors of medicine with doctors of osteopathy "should now be applied individually at state level according to the facts as they exist"; now therefore be it

Resolved, that —previous opinions to the contrary notwithstanding—the Judicial Council of The Medical Society of New Jersey now declares that hereafter in New Jersey it shall not be unethical for members of The Medical Society of New Jersey to enter into voluntary professional association with any person holding a full license as a physician and surgeon granted by the State Board of Medical Examiners of New Jersey who adheres to the same scientific principles embraced by the members of The Medical Society of New Jersey.

Upon motion by Dr. Collins—seconded by Dr. Bedrick, and unanimously carried—the Board received, with commendation, the opinion of the Judicial Council.

REPORT OF AMA DELEGATES

In the unavoidable absence of Dr. Costello, Chairman of the Delegation, the Executive Officer presented in his behalf the report on the AMA New York City meeting.†

Upon motion by Dr. Kaufman, the report of the AMA Delegates was accepted.

On behalf of Dr. Costello, the Executive Officer asked that the Board amend its stipulation concerning the schedule of conferences of delegates to be held in the course of AMA meetings, as adopted by the Board at its meeting on December 20, 1959. The stipulation in question declares that a conference of delegates should be held ". . . on the night before the first meeting of the AMA House of Delegates." Dr. Costello asked that this be amended to read "that a conference of delegates should be held, *'at the discretion of the chairman and the other members of the delegation,'* on the night before the first meeting of the AMA House of Delegates."

Upon motion by Dr. Greifinger, the Board approved the amendment.

Upon motion by Dr. Allman—seconded by Dr. Featherston, and carried—the Board unanimously adopted the following:

That no conferences of delegates be held in the hospitality room during the open hours posted.

COUNCIL ON LEGISLATION

In the absence of Dr. Lloyd, the Executive Officer presented the recommendations of the Council on Legislation, taken at its meeting on June 21, 1961.

Having considered each bill individually, the Board *approved* the council's recommended positions concerning the following pieces of state legislation.

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†See page 576 this JOURNAL.

S-150 *Stout*—To provide that services performed by a duly registered bioanalytic laboratory are within the scope of medical service plans. *No Action.*

S-173 *Connery*—To permit an injured employee to select the physician he wishes to treat him under the Workmen's Compensation Act. *Approval.*

S-189 *Fox, Hillery*—To expand and clarify the State Department of Health's jurisdiction over drug manufacturing and wholesale drug business. *Approval.*

S-221 *Farley*—To appropriate $15,000 for education of a special experimental group of multiple handicapped blind children. *No Action.*

S-222 *Dumont*—To make certain diseases of volunteer firemen occupational diseases. *Disapproval* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

A-10 *D'Aloia, Martin, Franklin*—To regulate the furnishing of public medical services through county welfare boards under the supervision of a new Bureau of Public Medical Services in the Division of Welfare of the Department of Institutions and Agencies. *Approval* . . . with conversion to *Active Support* upon introduction of recommended amendments.

A-250 *Kraut*—To eliminate reference to operation of a motor vehicle under the influence of intoxicating liquor from present motor vehicle laws, and leave same applicable to narcotics and habit forming drugs. *Disapproval* . . . because it constitutes an invasion of the Medical Practice Act.

A-511 *Hughes, et al.*—To amend the Radiation Protection Act of 1958 to define more clearly the regulatory department's powers. *Approval.*

A-531 *Hughes, Frederick and Koenig*—To make amendments to the Act regulating the practice of ophthalmic dispensing. *Disapproval* . . . consistent with the Society's opposition to optometrists' prescribing and fitting contact lenses, because ophthalmic technicians are even less qualified than are optometrists.

A-547 *McGowan and Sarcone*—To make possession by unauthorized persons of certain barbiturates, hypnotic and tranquilizing drugs without a prescription a disorderly persons' offense. *Approval.*

A-567 *Sarcone, D'Aloia*—To provide tenure of office for certain county chief medical examiners in first class counties under certain conditions. *No Action.*

A-586 *Brady, Kijewski and Musto*—To define "resident" of a boarding home for sheltered care and permit standards to be fixed by the State Department of Institutions and Agencies, upon recommendation by the Hospital Licensing Board. *No Action* . . . pending further study and report by the Legislative Analyst.

A-587 *Brady, Kijewski and Musto*—To broaden the scope of the registration and licensing of nursing homes and private hospitals. *No Action* . . . pending further study and report by the Legislative Analyst.

A-639 *Franklin and Hughes*—To increase allowances for reimbursement from federal and state funds for community mental health projects. *No Action.*

A-646 *McGowan*—To require the filing by September 1, for statistical purposes only, personal property tax returns despite suspension of filing until 1962. *Disapproval* . . . because it would be an imposition to the taxpayers for no practical purposes except to serve as a dry-run for the convenience of the tax collection agency.

A-662 *Hughes and Franklin*—To provide that data secured in research studies concerning the morbidity and mortality from any cause or condition of health shall be kept in confidence by the Health Department. *Approval.*

A-669 *Wilson and others*—To establish medical assistance for the aged, complementing present old age assistance, and making provisions consistent with requirement for receiving federal matching funds. *Disapproval* as a substitute for A-10, because A-10 is a more comprehensive public medical care program.

A-681 *Hughes and others*—To change the definition of "narcotic drugs" to provide a more effective basis for the prevention of illegal use of narcotics. *Approval.*

A-700 *Brady and Kijewski*—To authorize the formation of corporations not for profit for the purpose of providing health centers. *Disapproval* . . . because the bill is loosely drawn and its purposes unclear.

A-702 *Brady and Kijewski*—To provide that when any county maternity hospital is ready for occupancy the director of the board of chosen freeholders shall (with the consent of the board) appoint a board of managers of 5 members; eliminates the requirement that 3 of such members shall be physicians. *Disapproval* . . . because the bill is in violation of the public interest.

A-703 *Brady and Kijewski*—To permit boards of chosen freeholders to provide for a gynecologic service in county maternity hospitals. *Disapproval* . . . because the bill is in violation of the public interest.

A-719 *Brady*—To require that tags, caps, or labels of containers of cream be marked with the day it was pasteurized. *Disapproval* . . . in conformity with the opinion of the U. S. Department of Health, Education, and Welfare that "the disadvantages are more significant than any advantages that may now be claimed for the dating of pasteurized milk" and in support of the contention of the Department of Health that the bill is not warranted or necessary.

The Board received as information the council's report on the following positions of state legislation:

S-175 *Grossi and others*—To extend the application of Chapter 51, P.L. 1960, concerning the manner of assessment of real and personal property to taxes due and payable for the year 1963 instead of 1962.

S-176 *Grossi and others*—To amend Chapter 51, P.L. 1960, concerning the assessment of real property so that any increase or decrease assessed on property for the tax year 1962 may be staggered over a period of three years.

A-620 *Panaro and others*—To establish a program of health benefits for state employees.

The Board *modified* the council's recommended positions on the following pieces of state legislation:

A-647 *Franklin and others*—To establish the power of the State Board of Institutions and Agencies to classify the functions and establish specialized facilities and services of various institutions.

A-648 *Franklin and others*—To make technical amendments in statutes dealing with mental incompetents and their guardians.

A-649 *Franklin and others*—To revise generally the laws dealing with mental health and mentally retarded persons, an Act to be known as the "Mental Health Act of 1961."

Concerning these three bills the council recommended *No Action* . . . pending analysis and full study. The Legislative Analyst was able to bring to the Board the results of his analysis and study on all three measures. Extended discussion—especially of A-649—followed, in which objections were carefully weighed.

Upon motion by Dr. Hughes—seconded by Dr. Buchanan, and carried—the Board voted to *approve* these three measures, A-647, A-648, and A-649.

A-654 *Werner, Koenig and Kraut*—To permit suspension or revocation of medical license where the holder has been guilty of willful or gross malpractice or negligence endangering life.

Concerning this bill, the council recommended *Approval in Principle.*

This bill has been withdrawn at the request of the State Board of Medical Examiners for further study and amendment by them.

In view of this fact, the Board adopted a position of *No Action.*

COUNCIL ON OCCUPATIONAL HEALTH

The Society has been urged to send a representative to the Denver meeting of the AMA Council on Occupational Health.

Upon motion by Dr. Greifinger—seconded by Dr. Allman, and carried—Delma W. Caldwell, M.D., chairman of the Society's Special Committee on Industrial Health, was authorized to attend the Council meeting in Denver as the Society's official representative, with expenses paid.

MAJOR MEDICAL INSURANCE

Upon motion by Dr. Featherston—seconded by Dr. Kaufman, and carried—the subject of major medical insurance, tabled at the June 18, 1961, meeting, was taken from the table.

Dr. Featherston moved—seconded by Dr. Bedrick, and carried (Dr. Allman and Dr. Greifinger voting in the negative) that the Board adopt the original recommendation of the Committee on Medical Defense and Insurance as presented to the House of Delegates and referred by the House to the Board of Trustees for study and action:

That the Society adopt the proposal of the National Casualty Company for major medical insurance with $500 deductible, and that the E. & W. Blanksteen Agency be approved as the official brokers for this program.

Medicare Authorizes Cardiac Catheterization

The Medical Society received the following from the Office of Dependents' Medical Care in connection with Medicare for Dependents of Servicemen:

1. Patients suffering from cardiovascular conditions where cardiac catheterization is indicated and required by medical authority (charge physician) in the management of the illness will be considered to be "acutely ill." This establishes authorization of the procedure for payment in the future, but it is not retroactive.
2. After September 1, 1961 the cardiac catheterization procedure *on an inpatient basis,* will be considered as authorized care whether or not the procedure is followed by definitive surgery.
3. Claims for this bearing a "From" date not earlier than 1 September 1961 may be processed for payment.

Special and Liaison Representatives, and Special Committees — 1961-62

1. Aged, New Jersey Joint Council to Improve the Health Care of the

   William H. Hahn, M.D., Chairman, Newark
   David Eckstein, M.D., Trenton
   John F. Kustrup, M.D., Trenton
   John B. Fuhrmann, M.D., Flemington

   Equal representation from:
   New Jersey Hospital Association
   New Jersey State Dental Society
   New Jersey State Nurses' Association
   Licensed Nursing Homes of New Jersey, Inc.

2. American Medical Education Foundation, New Jersey Chairman

   Luke A. Mulligan, M.D., Leonia

3. Audit Committee (1960-61 Audit)

   Carl N. Ware, M.D., Chairman, Shiloh
   Frank J. Hughes, M.D., Gloucester
   Joseph R. Jehl, M.D., Clifton

   Consultants:
   Treasurer (Daniel F. Featherston, M.D., Asbury Park)
   Chairman, Committee on Finance and Budget (David B. Allman, M.D., Atlantic City)
   Administrative Secretary (Mrs. Edith L. Madden, Trenton)

4. Blood Bank Commission of New Jersey

   Authorized agent of Medical Society in approved Blood Bank programs

5. Blood Bank Commission Representatives

   Kenneth E. Gardner, M.D., Bloomfield
   Jerome G. Kaufman, M.D., Maplewood

6. Blue Cross and Blue Shield Plans of N. J., Permanent Committee on

   Chairman, Board of Trustees (Luke A. Mulligan, M.D., Leonia)
   President (Ralph M. L. Buchanan, M.D., Phillipsburg)
   Executive Officer (Mr. Richard I. Nevin, Trenton)
   Equal representation from MSP and HSP

7. Chamber of Commerce Legislative Conf[illegible] ences

   Executive Officer (Mr. Richard I. Nev[illegible] Trenton)

8. Chronic Sick, State Advisory Council (appointed by Governor)

   William D. Kimler, M.D., Haddon Heigh[illegible] (1964)
   Johannes F. Pessel, M.D., Trenton (1957

9. Civil Defense Organization, State

   Chairman, Committee on Disaster Medic[illegible] Services (R. Winfield Betts, M.D., Me[illegible] ford)

10. Crippled Children Commission, State (appointed by Governor)

    Frederick G. Dilger, M.D. (1966)

11. Diabetes Detection Drive (1961)

    John J. Torppey, M.D., Newark

12. Disaster Control, Joint Committee with Hos[illegible] pital Association

    Special Committee on Disaster Medica[illegible] Services

13. Directory Planning Committee, N. J. Conference on the Handicapped

    Elmer J. Elias, M.D., Trenton (Chairman, Special Committee on Rehabilitation)

14. Disputed Claims, Advisory Committee to Review MSP and HSP

    1st District—F. Clyde Bowers, M.D., Chairman, Mendham
    Elton W. Lance, M.D., Vice-Chairman, Rahway

    2nd District—John J. Bedrick, M.D., Bayonne
    Robert A. Cosgrove, M.D., Jersey City

3rd District—Gerard R. Gessner, M.D., New Brunswick
John A. Kinczel, M.D., Trenton
4th District—Reuben L. Sharp, M.D., Camden
John C. Clark, M.D., Asbury Park
5th District—Nicholas E. Marchione, M.D., Vineland
John S. Madara, M.D., Salem
(Quorum: 4 members)

15. Education, Advisory Council to State Department of
(appointed annually by Commissioner of Education)

C. Byron Blaisdell, M.D., Asbury Park

16. Education, Liaison with State Department of

Chairman, Special Committee on Child Health (Robert E. Jennings, M.D., South Orange)

17. Epilepsy, Advisory Panel on (to Director of Motor Vehicles)

Chairman, Special Committee on Mental Health (Robert S. Garber, M.D., Belle Mead)

18. Epilepsy Project, N. J. Consultation Service for Convulsive Disorders

Chairman, Special Committee on Mental Health (Robert S. Garber, M.D., Belle Mead)

19. Executive Committee
(Bylaws, Chapter IV, Section 5 b.)

President (Ralph M. L. Buchanan, M.D., Phillipsburg)
President-Elect (Louis S. Wegryn, M.D., Elizabeth)
First Vice-President (Carl N. Ware, M.D., Shiloh)
Second Vice-President (Charles H. Calvin, M.D., Perth Amboy)
Chairman, Board of Trustees (Luke A. Mulligan, M.D., Leonia)

20. Fluoridation, Joint Committee on

Louis S. Wegryn, M.D., Elizabeth
Charles H. Calvin, M.D., Perth Amboy
Representatives from State Department of Health and N. J. State Dental Society

21. Health Insurance Conference

Daniel F. Featherston, M.D., Chairman, Asbury Park
John J. Bedrick, M.D., Bayonne
Royal A. Schaaf, M.D., Califon
Marcus H. Greifinger, M.D., Newark
President-Elect (Louis S. Wegryn, M.D., Elizabeth)
First Vice-President (Carl N. Ware, M.D., Shiloh)
Second Vice-President (Charles H. Calvin, M.D., Perth Amboy)
Executive Officer (Mr. Richard I. Nevin, Trenton)
Eight representatives from Health Insurance Council

22. Health, Liaison with State Department of
John B. Fuhrmann, M.D., Flemington (Chairman, Council on Public Health)

23. Historian-Archivist
Fred B. Rogers, M.D., Trenton (Chairman, Committee on Publication)

24. Hospital Advisory Council, State Department of Institutions and Agencies
(appointed by Board of Control)

Luke A. Mulligan, M.D., Leonia (1961)
C. Byron Blaisdell, M.D., Asbury Park (1963)

25. Hospital Service Plan Liaison Committee

21 county Advisory Committees to MSP

26. Hospital Service Plan Board of Trustees
(per HSP Bylaws)

President (Ralph M. L. Buchanan, M.D., Phillipsburg)

27. House Maintenance, Staff Policies, and Personnel Relations, Special Committee on

President (Ralph M. L. Buchanan, M.D., Phillipsburg)
President-Elect (Louis S. Wegryn, M.D., Elizabeth)
Chairman, Board of Trustees (Luke A. Mulligan, M.D., Leonia)
Chairman, Committee on Finance and Budget (David B. Allman, M.D., Atlantic City)
Secretary (Marcus H. Greifinger, M.D., Newark)
Treasurer (Daniel F. Featherston, M.D., Asbury Park)

Chairman, former House Committee (L. Samuel Sica, M.D., Trenton)

Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)

Administrative Secretary, Ex-Officio (Mrs. Edith L. Madden, Trenton)

28. Institutions and Agencies, Liaison with State Department of

Frank J. Hughes, M.D., Gloucester

29. Lay Health Organizations and Paramedical Groups, Official Intermediaries with

Members of the Council on Public Health as assigned by the chairman.

(assignment of official intermediaries from The Medical Society of New Jersey to lay health organizations and/or paramedical groups does not imply endorsement of the organization or group or its program)

30. Legislative Keyman, National

C. Byron Blaisdell, M.D., Asbury Park

31. Medical Care and Labor (Conference with Labor)

Executive Committee (see No. 19)

32. Medical-Hospital-Nursing Conference (Tri-Partite Conference)

President (Ralph M. L. Buchanan, M.D., Phillipsburg)

President-Elect (Louis S. Wegryn, M.D., Elizabeth)

Immediate Past-President (Jesse McCall, M.D., Newton)

Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)

Equal representation from New Jersey Hospital Association and New Jersey State Nurses' Association

33. Medical Liaison Committees (Dental, Legal, Hospital, Nursing, and Pharmaceutical)

President (Ralph M. L. Buchanan, M.D., Phillipsburg)

President-Elect (Louis S. Wegryn, M.D., Elizabeth)

Immediate Past-President (Jesse McCall, M.D., Newton)

Executive Officer, Ex-Officio (Mr. Richard I. Nevin, Trenton)

(where number of representatives from other organization is larger than number of Medical Society representatives the latter will be increased from the Presidential Officers to equal the former)

34. Medical-Surgical Plan Board of Trustees (per MSP Bylaws)

President (Ralph M. L. Buchanan, M.D., Phillipsburg)

35. Medical-Surgical Plan Liaison Committee

6 Officers of The Medical Society of New Jersey

21 county chairmen of Advisory Committees to MSP

36. Medicare Fiscal Agent

Medical Service Administration of New Jersey

37. Medicare Program, Special Committee on

Carl N. Ware, M.D., Chairman, Shiloh

Nicholas A. Bertha, M.D., Wharton

Joseph R. Jehl, M.D., Clifton

L. Samuel Sica, M.D., Trenton

38. M'Naghten Rule, Special Study Committee on

President (Ralph M. L. Buchanan, M.D., Phillipsburg)

Chairman, Board of Trustees (Luke A. Mulligan, M.D., Leonia)

Immediate Past-President (Jesse McCall, M.D., Newton)

Counsel (Mr. Robert M. Backes, Trenton)

Executive Officer (Mr. Richard I. Nevin, Trenton)

Representatives from New Jersey State Bar Association

39. Motion Pictures, Radio, and Television, Advisory Committee on

Thomas C. DeCecio, M.D., Cliffside Park

Thomas J. White, M.D., Jersey City

Joseph M. Keating, M.D., Passaic

40. Motor Vehicles, Liaison with State Division

Chairman, Special Committee on Traffic Safety (A. M. K. Maldeis, M.D., Camden)

41. National Foundation Health Scholarship Committee

Vincent P. Butler, M.D., Jersey City (1961)

42. National Library Committee

Jesse McCall, M.D., Newton (1961)

43. Nurses' Recruitment, Special Committee on

Irving M. Levitas, M.D., Westwood

44. Nutrition Council, New Jersey

S. William Kalb, M.D., Newark

45. Osteopathic Medical Association, New Jersey

Executive Committee (see No. 19)

46. Pension Plan, Special Committee on

Chairman, Committee on Finance and Budget (David B. Allman, M.D., Atlantic City)
Chairman, Special Committee on House Maintenance, etc. (Ralph M. L. Buchanan, M.D., Phillipsburg)
Treasurer (Daniel F. Featherston, M.D., Asbury Park)

47. Public Health Association, New Jersey

Louis S. Wegryn, M.D., Elizabeth (Delegate)
Mr. Richard I. Nevin, Trenton (Alternate)

48. Retirement Plan for Physicians, Special Committee on

Jerome G. Kaufman, M.D., Chairman, Maplewood
John J. Bedrick, M.D., Bayonne
Albert F. Moriconi, M.D., Trenton
Morton F. Trippe, M.D., Asbury Park
Nicholas E. Marchione, M.D., Vineland
Mr. William Allen Steadman, Consultant, East Orange

49. Safety Council, New Jersey State
(per Council Bylaws)

President (Ralph M. L. Buchanan, M.D., Phillipsburg)
President's representative, Chairman, Committee on Traffic Safety (A. M. K. Maldeis, M.D., Camden)

50. Seton Hall Chapter of Student AMA, Advisory Committee to

Joseph P. Donnelly, M.D., Jersey City

51. Tuberculosis Council, State

John B. Fuhrmann, M.D., Flemington

52. Vendor Payment Medical Care Plan for Public Assistance Recipients
(appointed by Council on Medical Services)

Raymond J. Germain, M.D., Chairman, Lebanon
Harry R. Brindle, M.D., Asbury Park
Irving Klompus, M.D., Bound Brook
F. Clyde Bowers, M.D., Consultant, Mendham
Mr. Richard I. Nevin, Consultant (Trenton)

53. Widows and Orphans of Medical Men of New Jersey, Society for Relief of

Joseph R. Jehl, M.D., Clifton

Do You Have an Exhibit for 1962?

The 196th Annual Meeting of The Medical Society of New Jersey will be held at Haddon Hall, Atlantic City, May 12-16, 1962.

Applications for space in the Scientific Exhibits will be accepted by the Committee on Scientific Exhibits up to and including December 1, 1961. Notification of the committee's action will be made soon thereafter.

Forms may be obtained from the chairman by contacting the Executive Offices of the Society (telephone EXport 4-3154; mail P. O. Box 904, Trenton 5, New Jersey; or visit 315 West State Street, Trenton).

Members are cordially invited to apply for space in the Scientific Exhibits at the 1962 annual meeting, and are urged to obtain, complete and submit applications early.

AMA Annual Meeting, June 1961

A summary of our activities at the AMA Annual Meeting, June 1961, will be found in our July 1961 *Membership News Letter*. Matters of particular interest to New Jersey are further abstracted below.

The Medical Society of New Jersey was represented in all the sessions of the A.M.A. House of Delegates and in meetings of Reference Committees by its six official delegates: Drs. C. Byron Blaisdell, William F. Costello, Joseph P. Donnelly, Marcus H. Greifinger, Isaac N. Patterson, and L. Samuel Sica. Dr. Greifinger served as a member of the Credentials Committee and Dr. Patterson was a member of the Reference Committee on Amendments to the Constitution and Bylaws.

Also in attendance at sessions and reference committee hearings were Ralph M. L. Buchanan, M.D., our President; Louis S. Wegryn, M.D., President-elect; David B. Allman, M.D., former A.M.A. president; F. Clyde Bowers, M.D.; Frank J. Hughes, M.D.; Joseph R. Jehl, M.D., and John F. Kustrup, M.D.—alternate delegates; and Richard I. Nevin, Executive Officer.

New Jersey presented five resolutions for action by the A.M.A. House of Delegates, with the following results:

Resolution No. 56—Social Security for Physicians—to effect inclusion of physicians under Social Security—recommending that the House "approve the compulsory inclusion of physicians under Social Security and support national legislation to achieve that end." Despite vigorous support on the part of our delegates (and delegates from other constituent associations) the House—by a vote of 147 to 29—adopted the recommendation of the Reference Committee on Legislation and Public Relations that the A.M.A. "reaffirm its opposition to compulsory inclusion of physicians under Social Security." In doing so, it rejected resolutions submitted by New Jersey and New York and favored resolutions submitted by Arizona and Georgia.

Resolution No. 57—Assistant Secretary of Defense—to urge the re-establishment of the position of Assistant Secretary of Defense (Health and Medical). This matter was the subject of three similar resolutions and of a portion of the supplemental report of the Board of Trustees. The House approved the relevant section of the report of the Reference Committee on Legislation and Public Relations which declared, "The multiple responsibilities inherent in the proper organization, planning, and administration of this important service should rest in the hands of a qualified doctor of medicine rather than be a portion of the duties of a lay administrator."

Resolution No. 58—Influenza Immunization Campaign—to urge the A.M.A. "to evaluate and give leadership to an anti-influenza campaign, similar to that given in the campaign against poliomyelitis." The House adopted the report of the Reference Committee on Public Health and Occupational Health, which was "in accord with the resolution and heartily recommended its approval."

Resolution No. 59—Future Physicians Clubs—to urge that the "A.M.A. recommend that all county medical societies assume active leadership in this field by organizing local Future Physicians Clubs for the purpose of recruiting talented and dedicated students for careers in medicine." The report of the Reference Committee on Medical Education and Hospitals declared, in connection with this resolution: "your reference committee approves the intent of this resolution and suggests that whenever county medical societies organize Future Physicians Clubs, the program designed for the participating high school students should be carefully planned. When a medical school is to be involved in the activities of a club, it is highly important that the program be developed by the county medical society in cooperation with the medical school dean and faculty." The House adopted that portion of the report.

Resolution No. 88—Voluntary Professional Association Between Doctors of Medicine and Doctors of Osteopathy—"to urge the House of Delegates realistically to recognize the changing attitudes concerning, and relationships existing between, doctors of medicine and doctors of osteopathy holding full licenses as physicians and surgeons, and either to modify the Principles of Medical Ethics in adjustment thereto or to prevail upon the A.M.A. Judicial Council to revise its interpretation of the portions of the Principles of Medical Ethics pertaining thereto." The Reference Committee on Amendments to Constitution and Bylaws considered Resolution No. 88 together with Resolution No. 33 from the New York delegation and the report of the Judicial Council. It declared itself as concurring in the intent of the report and the resolutions. However, it recommended that, in lieu of the report and the resolutions, the House adopt a statement of A.M.A. policy which the reference committee supplied (see report in our July 1961 *Membership News Letter*).

Dr. Issac N. Patterson submitted a minority report, urging the rejection of the majority report of the reference committee and the adoption instead of the report of the A.M.A. Judicial Council as being more specific and definitive. The House, however, after rather extended discussion rejected Dr. Patterson's minority report and adopted instead the majority report of the reference committee.

Manufacturers' Position on H. R. 6471

Following are excerpts from statements made September 21, 1961 to the Commerce Committee of the House of Representatives. These remarks were made by Theodore G. Klumpp, M.D. Dr. Klumpp is president of Winthrop Laboratories and here serves as spokesman for the Pharmaceutical Manufacturers Association. The references are to H. R. 6471, the so-called "full disclosure" bill.

The Pharmaceutical Manufacturers' Association supports the "full disclosure" objective of H.R. 6471. Our members, in fact, are pledged to full disclosure to the medical profession with respect to our products. This has long been the practice of reputable manufacturers. We believe strongly in this policy because a physician needs this information to fulfill his professional obligation properly when prescribing our products. We disseminate this information through all appropriate channels.

The purpose of H. R. 6471 is to promote such disclosure. This purpose is consistent with the policy of the Pharmaceutical Manufacturers' Association. Although the bill in its present form is extreme and unworkable, we feel that with certain modifications H. R. 6471 can be made to achieve its purpose.

The Federal Trade Commission Act now provides that if an advertisement of a drug to the medical profession sets forth the formula of the drug quantitatively it shall not violate the Act unless the advertisement contains a *false* representation of a material fact. This Section provides that "labeling" of a drug is not advertising and, therefore, not subject to the jurisdiction of the Federal Trade Commission. These provisions spring from Congressional recognition that physicians constitute a special audience because they are highly trained professional people. These provisions reflect Congressional awareness of the unique role that the Food and Drug Administration plays for physicians by seeing that all relevant information concerning drug products is readily available to physicians in drug labeling. Congress has charged the *Federal Trade Commission* to see that advertisements to the profession contain no false statements. On the other hand, Congress has charged the *Food and Drug Administration* through the labeling of these products, to see that the medical profession is promptly and fully informed concerning them. This express dichotomy of jurisdiction and function between the *Federal Trade Commission* (advertising) and the *Food and Drug Administration* (labeling) is based upon the realization of the role and purpose of the agencies and reflects an abiding Congressional wisdom.

H. R. 6471 would delete the foregoing provision of the Federal Trade Commission Act dealing with advertisements of drugs disseminated only to the medical profession. It would also require that all advertisements of prescription drugs would be "misleading in a material respect" (and, therefore, subject to suit by the Federal Trade Commission) if they did not list the side effects and contraindications of the drug. H. R. 6471 directs the Commission to prescribe "such rules and regulations as may be necessary" to administer these provisions.

H. R. 6471 seeks a radical change in Congressional policy. The proponents of H. R. 6471 feel either that (a) the Congressional recognition of the medical profession as constituting a special audience (insofar as drug advertising is concerned) is no longer warranted or (b) physicians prescribe drugs merely on the basis of advertisements without consulting their professional experience or available literature. Neither of these assumptions is, in fact, valid.

The American Medical Association has objected concerning H. R. 6471 that physicians deplore the implication that they are prescribing drugs without having sufficient information about them.

The provisions of H. R. 6471 fail to recognize the function of medical advertising and do not give sufficient consideration to the other ways in which a physician gets his information about prescription drugs.

Medical journal advertising is only one of the physician's many sources of information about drugs. He is trained in the properties and utility of all principal drugs. In active practice, physicians supplement this training by regular reading of the medical journals, which publish disinterested evaluations of the newest drugs, written by toxicologists, clinical investigators and others who write according to rigid standards of accuracy and objectivity.

In addition, the physician receives a wide range of information from the pharmaceutical companies. With respect to new drugs these companies give physicians a full statement in brochure form of all available information concerning the product in question. Before releasing this brochure the company must submit it to the Food and Drug Administration. The final version reflects the views and modi-

fications of the Food and Drug Administration and is disseminated as specified by the Agency. In effect, this brochure is an approved documentary report of all aspects of the drug including indications, dose, methods of use, clinical and other experience, side effects and contraindications. The size and content of these brochures will vary with each product. These brochures are kept up to date. The procedure concerning the content and dissemination of revisions is precisely the same as the procedure for the initial brochure. The American Medical Association and the United States Pharmacopoeia will put these brochures in uniform style size and format and distribute them through their own facilities to physicians and pharmacists. This will go even further to assure that the physician has before him (in a handy and usable form) all the information about side effects, contraindications and other matters that the Food and Drug Administration deems to be desirable.

This plan should be in effect during 1962 and will increase the already great impact and authority of these brochures in the minds of physicians. In addition to these, the companies send to physicians letters, samples and other detailed information concerning their products. They also send representatives to make professional visits in which they answer the doctor's questions face to face, and provide him with additional information.

The great majority of pharmaceutical companies are extremely careful in the information they transmit to doctors. Their most priceless asset is the confidence of the doctor in their integrity—a confidence built up by years of professional experience with the company's products and with the accuracy, objectivity and completeness of the information the companies supply to him. The standard of integrity of the pharmaceutical companies matches the high standard of the medical profession and of the government service.

Entirely apart from what the physician reads in an advertisement, he has at his command from the manufacturer a vast quantity of information about each drug whether it be a new drug or an old one. In judging the accuracy and completeness of this information he may rely not only on the knowledge of the integrity of the particular manufacturer, but also on the close control exercised by the Food and Drug Administration.

It is virtually impossible, even if it were desirable, to include in an advertisement all the information concerning the indications, actions, warnings, side effects, contraindications, etc. Any suggestion or implication in an advertisement to the effect that it *does* tell the whole story would, in most cases, be misleading. A substantial portion of drugs cannot be safely administered without accurate knowledge on the part of the physician of extensive directions for use, contraindications and possible untoward effects. Full information concerning these can often be presented only in several pages of written matter. Who is to judge what portion of this information is enough to satisfy the varying needs of practicing physicians? For one patient, one direction or warning may be vital; for another, some other portion of the whole story may be critically important. Anything less than the whole story may confer a false sense of security and thus, a simple reminder advertisement may be transformed into something misleading. A little knowledge is a dangerous thing. Anything less than the *whole* truth may do more harm than good. In its day to day practical applications, H. R. 6471 would require that "the partial story" be presented as if it were, in fact, "the whole story." These requirements of H. R. 6471 would tend to undermine the traditional and highly effective means of communicating such information to physicians thereby impeding the efforts of the Food and Drug Administration and others to make the traditional system even more effective and reliable.

The medical journal advertisement is primarily intended as a reminder. It calls the physician's attention to a drug about which he already possesses detailed written information. The American Medical Association has pointed out that no physician should prescribe a drug solely on the basis of what he reads in a medical journal advertisement. No physician relies on a medical journal advertisement to include *all* the pertinent information about a drug that he requires in order to prescribe it. Such advertisements should not be judged by the standards of an SEC prospectus, as if it were the principal source of the doctor's information about a drug. Those who urge that medical advertisements be judged by the standards of an SEC prospectus are impliedly attacking the physicians' professional reliability and integrity.

There are important practical limitations upon what the pharmaceutical manufacturer should be required to include in the advertisement:

(1) The advertisement cannot include all the information about a drug relevant to a doctor's decision on whether to prescribe it. A medical journal advertisement is usually a half page or

a full page in size. Smaller companies may only be able to afford a quarter page or less. All of the pertinent information which the company supplies to the physician (and which the Food and Drug Administration properly requires him to supply) cannot possibly be printed on a quarter page, a half page or a full page, except in type so small that it cannot be read. It is like trying to print the Declaration of Independence on the head of a pin.

(2) There is no law requiring pharmaceutical companies to buy advertisements in medical journals. They are bought only because they perform a commercial function—the function of calling attention to a drug about which the doctor has already been informed through other means of communication. They will perform this function only if they attract the doctor's eye. If the copy is too long, the doctor will not read it any more than you or I would read the details of an insurance policy or of an SEC prospectus if they were crammed into an advertisement. The advertiser soon learns whether or not his advertisements are read. When they are not, he discontinues such advertising. The doctor's general custom is to glance through the advertisements and devote most of his available reading time to the scientific articles. If the advertisements are clogged with detailed reading matter, he won't bother to read them at all.

(3) Pharmaceutical advertising is the principal source of income of the medical journals. The scientific articles appearing in these journals are important sources of education for the medical practitioner. The proposed requirements placed on medical journal advertising will destroy the commercial function of such advertising. Many medical journals will be forced out of business, and a valuable source of medical knowledge would be lost. And a decrease in the number of medical journals will result in a serious delay in bringing scientific communications to the attention of the medical profession.

(4) Since it is impractical to place *all* the data in the advertisement, some information must necessarily be omitted. For example, some drugs may be useful in treating a variety of diseases but the manufacturer may wish to call the physician's attention to the use of the drug in a single disease. There is no reason why he should not be permitted to do so. Most drugs have side effects of various types on various classes of patients, some of them extremely important and some of much less importance. They cannot *all* be listed in the advertisement in such a way as to convey their relative importance and significance to the medical reader except by a detailed discussion—similar to that included in the package insert or brochure—which would take up too much space in the advertisement. H. R. 6471 makes no provision for this problem.

(5) The Food and Drug Administration has full jurisdiction over the content of all information referred to in H. R. 6471 and sees that it is transmitted to physicians in appropriate forms. No useful purpose would be served by also giving the Federal Trade Commission power to require that the same subjects be covered to its satisfaction in medical journal advertisements.

There is no disagreement between the Pharmaceutical Manufacturers' Association and the proponents of H. R. 6471 concerning the importance of full disclosure to physicians. We *do* disagree, however, on the means by which advertisements should properly be required to achieve this purpose. I have attempted to set forth the Pharmaceutical Manufacturers' Association's position in this statement. To resolve the problem and at the same time to assure that medical journal advertising refers the physician to the appropriate literature about side effects and contraindications we suggest that the following amendment be made instead of the amendment set forth in H. R. 6471:

"Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

The subsection (a) of Section 15 of the Federal Trade Commission Act is amended (1) by striking-out the period at the end of the last sentence of paragraph (1), and (2) by inserting in place thereof the following:

"and, if it is an advertisement of a prescription drug, contains the following statement: 'Before prescribing be sure to consult the manufacturer's literature for information about possible side effects and contraindications'. For the purposes of this paragraph a prescription drug is one intended for use of man that Federal law requires to be dispensed only upon the prescription of a practitioner licensed by law to administer such drug."

The above amendment to the present Section 15 would (a) adequately remind the physician that the advertisement of a prescription drug does not necessarily tell the full story of the product and refer him to the appropriate source of such a story, (b) preserve the accepted character of prescription drug advertisements as essentially reminder pieces that present only salient facts, (c) allow the medical journals to continue their important role of providing the physicians with current scientific reports, (d) draw increased attention to and thereby further the full disclosure program of Food and Drug Administration and other groups, (e) preserve intact the traditional roles and functions of the Federal Trade Commission and the Food and Drug Administration, and (f) allow manufacturers and editors to make their advertising judgments with certainty as to the law's requirements.

Announcements • • •

Social Aspects of Arthritis

Copies of the October, 1961 issue of *Public Health News,* which carries several papers on the socio-cultural aspects of arthritis, are available to physicians on request to the State Department of Health, Trenton 25, New Jersey.

Tumor Symposium in New York

Columbia University is sponsoring a three-day symposium, titled "Basic Problems in Neoplastic Disease," March 12, 13, and 14, 1962.

An outstanding group of scientists from all over the world will participate in sessions on nucleic acid structure and synthesis; viral and genetic studies; protein synthesis; antibody structure and function. In addition, sessions devoted to clinical aspects of the biochemistry, pathological-physiology, morphology, and therapy of cancer will be held.

The Symposium is open without fee to all readers of this JOURNAL. For details write to the Institute for Cancer Research, College of Physicians and Surgeons, 630 West 168th Street, New York 32, New York.

Allergy Course

The American College of Allergists Graduate Instructional Course and Eighteenth Annual Congress will be held April 1 to 6, 1962, Hotel Radisson, Minneapolis. For further information, write to: John D. Gillaspie, M.D., 2141 14th Street, Boulder, Colorado.

New FACS Holders in New Jersey

The following members of The Medical Society of New Jersey were inducted as Fellows of the American College of Surgeons on October 5 in Chicago:

Donald C. Adrian, Levittown
Donald T. Akey, Metuchen
Myron Bash, Trenton
Anthony P. Caggiano, Montclair
John H. Caputi, Camden
Paul L. Chodosh, Elizabeth
Sidney Cohn, Passaic
Robert B. Connolly, North Bergen
Luciano E. DeMarco, Newark
Stanley Edelken, Long Branch
Robert Edelmann, Jersey City
Donald A. Fonda, Ridgewood
Franklyn P. Gerard, Newark
Francis E. Gilbertson, Red Bank
George C. Godfrey, Ocean City
Jack Grundfest, Kearny
Stanley J. Gusciora, Passaic
Jonathan A. Hammond, Trenton
David E. Landers, Teaneck
S. Stuart Mally, Atlantic City
John J. McCarthy, North Bergen
Urie A. Parkhill, Asbury Park
John D. Preece, Trenton
John M. Pulliam, Jr., Camden
Anne J. Robbins, Jersey City
Zelig A. Rosen, Dover
Herbert S. Rosenthal, Paterson
Eugene P. Salvati, Plainfield
S. Lawrence Samuel, Plainfield
Anthony M. Sarno, Newark
Albert A. Schwartz, Perth Amboy
Myron J. Shapiro, Irvington
David B. Siebert, Point Pleasant
David B. Simpson, Bayonne
Eugene J. Slowinski, Newark
Robert L. Sperry, North Bergen
James H. Spillane, Phillipsburg
Robert K. Spiro, Bloomfield
Wilson D. Webb, Jr., Hackensack
Sidney F. Wein, Passaic
Francis S. Weinstein, Newark
William L. Wood, Red Bank

Obituaries

DR. THOMAS P. GLEASON

Dr. Thomas P. Gleason of Bayonne died suddenly on July 7 at the age of 55. Born in Bayonne, Dr. Gleason received his early education in Bayonne schools and graduated from Georgetown University School of Medicine in 1934. He interned at St. Francis Hospital, Jersey City and was on the staff of the Bayonne Hospital.

DR. JOSEPH J. RUVANE

Born in 1898, Dr. Joseph J. Ruvane died at the Jersey City Medical Center on September 13. Dr. Ruvane received his M.D. at Georgetown in 1924, and did graduate work in orthopedics at the Hospital for Joint Diseases in New York City. He was active in the work of the New Jersey Orthopedic Society. Dr. Ruvane served the Jersey City Medical Center in all grades on its orthopedic service, and at the time of his death, and for some years prior, was Director of Orthopedics there. He was also affiliated with the Hudson County Mental Hospital and was senior attending orthopedic surgeon at St. Francis Hospital in Jersey City.

DR. NATHAN L. SHULMAN

A cerebral hemorrhage took the life of Dr. Nathan L. Shulman on September 1 in the emergency room of the North Hudson Hospital. Dr. Shulman was an obstetrician and general surgeon. He was born in Europe in 1900 but was brought to the United States in childhood and attended the Union City public schools. In 1923 he received his M.D. at the Jefferson Medical College of Philadelphia. An attending surgeon at North Hudson Hospital, he was a Fellow of the International College of Surgeons. Dr. Shulman was active in the affairs of the Hudson County Medical Society.

County Society Reports

Cumberland

The *Cumberland County Medical Society* held its October 10th meeting at 2:00 p.m., at Richards Farm, Vineland, with Harry A. Reinhart, M.D., presiding. Thirty members attended.

The application of David A. Schwartz for Active membership by transfer from Delaware County Medical Society was unanimously approved. Dr. Schwartz has established a practice in obstetrics and gynecology in Vineland.

The following Associate members were welcomed: Drs. Paul Gutlohn, Peter Jespersen and Gilbert Martin of Bridgeton, and William W. Fithian of Millville.

The New Jersey Diabetes Association and the New Jersey State Department of Health will cosponsor a symposium on diabetes on October 25 in Montclair. This seminar is on "Liver and Diabetes."

Drs. Benjamin Berkowitz, Bridgeton, Albert B. Shapiro, Vineland and Richard E. Beck, Millville, were appointed by the president to serve on the Committee on Traffic Safety in cooperation with the Division of Motor Vehicles of New Jersey.

Our Maternal Welfare Committee, Mary Bacon, M.D., chairman, invited interested physicians to serve on the committee.

Frank J. T. Aitken, M.D., Bridgeton, reported the opening of a new out-patient department for psychiatric evaluation and after-care at Ancora State Hospital in Hammonton.

Francis N. Campagna, M.D., Vineland, who held the annual Eye Clinic at the Newcomb Hospital, Vineland, reported also for the Eye Clinic held by Samuel B. Pole, M.D., Bridgeton, at the Bridgeton Hospital in September.

The guest speaker was William H. Whiteley, M.D., a neurosurgeon at the Jefferson Medical College and Hospital. His title was: The Stroke Problem. He discussed the etiology, the diagnosis and surgical correction of apoplexy. Dr. Whiteley stated that occlusive disorders of the brain vessels were caused in part by arteriosclerosis, atherosclerosis,

brain tumors, aneurysms, embolism, among others. He discussed the use of arteriography in diagnosing problematic areas and augmented the discussion with lantern slides. He presented a number of cases that had been corrected by surgical procedure.

The meeting adjourned following a question and answer period.

LEONARD G. SCOTT, M.D.

Reporter

Salem

On Friday, September 15 at 4:30 p.m. the monthly meeting of the *Salem County Medical Society* was held at Richman's Restaurant in Sharptown. Present were 30 Active and one Associate members. In the absence of the president, Dr. William Sprout, the meeting was called to order by the vice-president, Dr. Wilbert Staub. Dr. Charles Gilpatrick introduced a resolution that the society take official cognizance of the death of Dr. Ewan, one of the local general practitioners, at the age of 101. A donation in Dr. Ewan's name will be made to the local Cancer Society.

Dr. Bailey Norton, chairman of the Committee on Constitution, reported on proposed changes in the constitution. These included a proposal to set up a category of Associate member.

Following the business meeting, Dr. Staub introduced the guest speaker, Hobart Reinman, M.D., Professor of Clinical Medicine and Chairman of Preventive Medicine at Hahnemann Medical School. He spoke on the abuse of anti-microbials.

After a brief question and answer period, all retired to enjoy a delightful dinner of broiled flounder or ham.

JOHN T. DOOLEY, M.D.

Reporter

Book Reviews

Management of Fractures, Dislocations and Sprains. H. E. Conwell, M.D. and F. C. Reynolds, M.D. St. Louis, 1961. Mosby. Ed. 7. Pp. 1153. ($27.00)

This rather lengthy treatise on fractures, dislocations and sprains is excellent if for nothing else in that it is extensively illustrated (1227 photographs!) It does, however, suffer from the failing of so many "inclusive" texts in that it includes many procedures long since outdated. I presume these are included for the sake of completeness of the record. I seriously doubt, for instance, that anyone now uses the Whitman method of treatment of the fractures of the neck of the femur.

The first four paragraphs on the generalization of the treatment on fractures do not supply an overabundance of details. The chapter on pathologic fractures is short; the chapter on open fractures and war wounds does *not* supply a good general picture of the basic principle of the underlying treatment of compound fractures. It leans too much toward the inclusion of metal internal fixation procedures and I am surprised to see the authors recommend that "a liberal amount of sulfanilamide or sulfathiasole powder or micro crystals should be sprinkled in the wound and a dressing applied."

Chapter 10 on injuries to the spine handles the subject particularly well. It reviews all possible uses and methods of treatment of the various levels of spinal injuries. In addition to this, the text on injuries in the region of the wrist (including the small bones of the hand) is beautifully handled.

The section on fractures of the neck of the femur goes into an unusual amount of detail with the procedures on internal fixation while Chapter 19 leans more towards traction and counter traction than it does to intermedullary pinning. This applies to the number of photographs with onlay types of internal fixation for fractures of the upper and mid-third of the femur. In a discussion in Chapter 23 of the so-called "march fractures" the authors fail to point out that the positive x-ray findings usually do not appear until from 6 to 10 days after the onset of the pain, which is sometimes misleading and causes a delay in the diagnosis.

This treatise can be highly recommended for a reference text since the profusion of its illustrations permit an easy method of comparison with other types of fractures. The book is quite complete in the presentation of the unusual and serious type of fracture.

DANIEL F. FEATHERSTON, M.D.

Atlas of Obstetric Technic. J. R. Willson, M.D. St. Louis, 1961. Mosby. Pp. 304. ($14.50)

Dr. Willson emphasizes the need for a suitable reference guide to management of specific problems of labor and delivery which cannot be described or illustrated in detail in the standard obstetric texts. This volume has been admirably prepared to fill this need. The illustrations are dynamic and graphically present the various situations in clear drawings so constructed through transparent and partial cutaway structures, that they convey a three dimensional sense unusual in such a text. This leads to great ease in understanding the complicated position changes and relationships in obstetrical maneuvers.

The text is a precise and direct guide which can be followed step by step through each clinical situation and procedure. It follows the pictures rather than the opposite. The discussion is simply worded with a minimum of labels and "proper name" terminology. Each problem is presented briefly but well, in a general discussion, pointing out objectives, etiology, hazards and precautions.

The author presents only one type of management. Those skilled in and favoring the primary choice of specialized obstetrical forceps (such as the Kielland and Barton instruments to meet specific arrest and rotation problems) may take exception to Dr. Willson's use of the classical instruments almost exclusively, with the attendant pelvic rather than the cephalic applications. As an overall guiding text for all hospitals, however, the author's view is reasonable. The only confusing and unnecessary discussion occurs in word descriptions of the "position" of forceps in the pelvis. This should have been eliminated.

Management of premature separation of the placenta is conspicuous by its absence. This would seem to fall within the scope of this *Atlas*. I hope this will be included in future editions.

The precise presentation of version procedures is valuable in view of present day decreasing familiarity with them; but with the simultaneous necessity for proper performance when such procedures are indicated.

This *Atlas* is an outstanding contribution to the obstetrical literature and a valuable guide which should be readily available to all hospitals and physicians managing obstetrical problems.

J. B. SKELTON, M.D.

American Academy of Orthopedic Surgeons Instructional Course—1960. Fred C. Reynolds, M.D. Editor. St. Louis 1960. Mosby. Pp. 421. ($18.00)

The current volume of the Instructional Course Lectures, the 17th in the annual series, is written primarily for the orthopedic surgeon. It includes detailed presentations on Workmen's Compensation disability evaluations and on bone graft surgery, as well as an excellent review of surgical approaches to the cervical spine. There is a section on athletic injuries which encompasses problems met by team physicians and other people treating young athletes, including the "overuse syndrome" and athletic injuries of the limbs.

Of more general interest is symposium on fractures of the neck of the femur. Primary emphasis is on technics. However, there is an excellent analysis on the current philosophy and trends in the handling of this difficult problem. Of particular interest is John Hinchey's report of results in the use of the Moore prosthesis in femoral neck fractures in old patients. Real progress has been made in this area, where in the past, healing of the intercapsular fracture was so often delayed, and frequently when it occurred, was followed by late aseptic necrosis. Dr. Hinchey's ability to ambulate these patients early without having to wait for fracture healing is of particular value in this age group.

This series continues to be an excellent reference material for the orthopedist and for use in the general hospital library, but probably is of limited use for the non-specialist except as a reference book.

ROBERT GEORGE GREENE, M.D.

Congenital Malformations of the Heart. Helen B. Taussig, M.D. Volume 2, Specific Malformations. Published for The Commonwealth Fund by the Harvard University Press. Cambridge, 1960. Pp. 1,049. ($17.50)

Since the publication of Dr. Taussig's book on Congenital Malformations of the Heart in 1947 great changes have occurred in the clinical recognition and in the treatment. Consequently, this revised edition has been eagerly awaited. The result has been all that one would have anticipated. Dr. Taussig has presented her subject in clearly expressed and readily understandable language. This work is for clinicians primarily concerned with clinical diagnosis, medical treatment, indications for surgery, but not surgical technics.

Volume II is a large book and gives a full presentation of specific malformations. With each chapter there is a well arranged discussion of the nature of the malformation, course of the circulation, physiology, clinical and cardiac findings, including x-ray, fluoroscopy and electrocardiography. Special tests are described, diagnosis and

differential diagnosis, treatment and prognosis are discussed.

All physicians and surgeons interested in congenital cardiac malformations will welcome this volume.

THOMAS WHITE, M.D.

How Your Government Makes it Possible for Employees to Retire Rich. Author not stated. Published 1960 by the Research and Reporting Register, Box 641, Rochester 3, New York. Pp. 92. Paper. Price not stated.

Proposals are frequently made to permit self-employed persons (such as medical practitioners) to enjoy certain tax benefits in building up a retirement fund. In voting against this bill, many Senators took the position that it would give self-employed people benefits which employees did not have. This brochure shows how employees' retirement funds enjoy tax benefits which permit employees to roll up large nest eggs at the expense of the self-employed taxpayer.

HENRY A. DAVIDSON, M.D.

The Kybernetics of Natural Systems. D. K. Stanley-Jones. New York 1960. The Pergamon Press. Pp. 145. ($6.50)

The concept of man as a machine seems timely these days. In this slender volume, Mr. Stanley-Jones ingeniously develops the concept of biologic structures as participants in a traditional input-output-feedback machine. The author shows how automation principles can be applied to such mechanisms as sphincter control or the maintenance of a peptic ulcer, for instance. The author takes us through the natural hierarchy from invertebrates to man; from man to society. The book cannot be tasted. It has to be masticated slowly and thoroughly. But it will repay such study in opening a fresh vista on an old problem.

HERBERT BOEHM, M.D.

Information, Please! For Women Only. By Alfred Dreyfus. New York, 1961. Vantage Press. Pp. 556. ($7.50)

This book starts with a superficial review of a variety of subjects—the gonorrhea "germ" and the syphilis "poison" being given great prominence. Also touched on are menstruation, ovulation (a completely different explanation is given later on), headache, neurasthenia, and sexual maladjustment. The writing is poor and the data hopelessly out of date; *e.g.* syphilis is never cured without a long course of mercurials. It seems to have been written much earlier than other parts of the book.

Then come three chapters devoted to a discussion of "safe period," using Ogino's and Knaus' studies. There are the Dunhill Charts. In italics it promises to be infallible.

The third section is a quick rehash of the Kinsey books, credit being given to Dr. Kinsey for most of the quotes. It is better written than the first section and makes more sense.

An appendix comprises two-thirds of the book. Each page starts with the date of the last menstrual period and lists the weeks of pregnancy numerically with the notation: x weeks late (all the way up to 40); one for each day of the year. The pages are identical in form and why there are 365 of them I do not know. This reviewer's reaction to the book was on the minus side. There are numerous books covering this subject for the laity which are very much better written and certainly more accurate medically.

ZELDA I. MARKS, M.D.

Cardiovascular Dynamics. By Robert F. Rushmer, M.D. Philadelphia, 1961. Saunders. Ed. 2. Pp. 503, illus. ($12.50)

With the introduction of newer technics in cardiovascular diagnosis, the need for understanding of basic physiology becomes greater all the time. In this book (now in its second edition) this want is fully satisfied for the practicing physician, as well as the clinical physiologist. In 16 chapters, Dr. Rushmer presents in lucid fashion the basic material needed to understand the presentation of the catheterization team, the phonocardiographer, the electrocardiographer and their confreres. At the same time, there is enough detail in each area to be of benefit to the specialist in the field when he needs ready reference material.

In a book of this type, the succinct, lucid presentation of material in a readable fashion is important but the illustrations are vital to a clear understanding of the subject. The author excels in both areas. He has not only digested and presented a huge mass of fact simply, but his illustrations are uniquely conceived and are often self-explanatory—which is unusual and most helpful. He has made excellent use of all of the new diagnostic technics in his illustrations, including cinefluorographic roentgenology to better impart the necessary information. Though many areas are still controversial and change will occur, the basic facts and their implications are here.

The book presents, then, in a most useful fashion, material of great value to the practicing physician, the specialist and the clinical physiologist who need or want information in the cardiovascular area. In a changing dynamic area, this book will furnish a foundation for understanding of much that is published today as well as much that will evolve in the future.

ARTHUR BERNSTEIN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

NOVEMBER, 1961 • VOL. XXXIV, No. 9

AMBULATORY TREATMENT OF TUBERCULOSIS

A group of tuberculous patients at an Army Hospital were graduated from ambulation to calisthenics to active sports without harmful results. The program was conceived to condition the patients for return to military duty.

On the basis of experience in this hospital and that of others, physical activity per se appears not to be harmful to the tuberculous process in the presence of chemotherapy.

Since an abrupt change in physical activity might occur when a patient was transferred from a status of convalescent leave to one of full military duty, it appeared appropriate to test the effect of this added physical stress in the hospital environment.

Therefore, a previous program of free ambulation was expanded to include a certain amount of controlled physical exercise, in the form of calisthenics. This was gradually increased to include competitive sports and full-time on-the-job work assignments.

PURPOSES OF STUDY

There were several purposes for undertaking this study: (1) to determine if a program of active physical exercise would be harmful in patients receiving adequate multiple-drug therapy; (2) to see if it would be feasible to shorten periods of convalescent leave and time off duty by physical reconditioning during hospitalization; and (3) to see if the use of this program would further strengthen in the patient's mind the philosophy of discouraging disability attitudes, particularly in the career soldier, and encouraging the patient to think and plan constructively for the future. It is hoped that educational programs and on-the-job training can be developed to the point that the patient, from a career standpoint, would be better off for having had this period of hospitalization. If no physical harm is done, there is no question that the psychologic and morale-building advantages would be many.

All of the patients (105) had previously untreated pulmonary parenchymal disease. Daily isoniazid and PAS were given to all but those unable to tolerate PAS; as a substitute, these patients received streptomycin. The last drug was also given as an additional drug to some patients with extensive disease.

On admission to the hospital, following initial examinations and institution of chemotherapy, the patients were started on regular occupational therapy and educational programs. Asymptomatic patients were expected to participate in active calisthenics for 15 minutes per day on a five-day week basis, beginning within two to four weeks of admission; however, calisthenics were not started in some patients with far advanced disease and large cavities until two months after admission. The calisthenics were approximately on the level of activity given to regular troops during their basic training period. Rest periods were eliminated for these patients.

James A. Wier, M.D., James M. Schless, M.D., Luke E. O'Connor, M.D., and Orman L. Weiser, M.D., *The American Review of Respiratory Diseases,* July, 1961.

When the patients reached the noncommunicable stage, without regard to roentgenographic change, active sports were added, including basketball, volleyball, golf, bowling, and swimming. Cavities had usually been resected by this time. A minimum of one hour of active sports a day, five days a week, was required. However, most patients engaged in two hours of sports. When noncommunicable status was reached, on-the-job training was added to the program. The patient was later given a job on the post and was gainfully employed on a full eight-hour-a-day schedule for several months prior to discharge.

In 62 per cent of the patients, the disease was either moderately or far advanced; 44 per cent had cavitary disease at the time of original diagnosis; 81 per cent had tubercle bacilli in the sputum at the time of original diagnosis.

TREATMENT RESULTS

The results of treatment, as judged by roentgenographic changes, showed that 82 of the patients had either marked or moderate roentgenographic improvement: 19 had slight improvement, and four had no significant roentgenographic change. No patient showed evidence of worsening.

Of the 46 patients with cavitary disease, 20 achieved complete healing within three to eight months on chemotherapy alone. In 24 additional cases, resectional surgery for residual cavities was performed after five to eleven months of treatment. Two patients were eventually discharged with the "open-negative" syndrome. No patients with cavities were discharged if their sputum was infectious, and in no instance was there evidence of enlargement of existing cavities or development of new cavitation during the period of observation.

Of the 105 patients, 33 were subjected to thoracotomy—24 for resection of residual cavitation, five for resection of extensive risidual nodular disease; in four cases, surgery was for diagnostic purposes.

INFECTIOUSNESS REVERSED

Reversal of infectiousness occurred rapidly. Seventy-one of the 81 patients with tubercle bacilli in the sputum pretreatment were noninfectious by the end of the second month. Only three patients were still discharging tubercle bacilli at the end of the fourth month. One became noninfectious at the end of six months and remained so thereafter. Two patients with noninfectious sputum at the end of two months had a single culture positive for tubercle bacilli at four months, and remained negative thereafter. Both of these patients eventually came to surgery, one at six and one at ten months. A single patient continued to discharge tubercle bacilli at the end of six months. His strain of tubercle bacilli was 100 per cent resistant to isoniazid at that time. At the end of seven months resectional surgery was performed.

The average duration of hospitalization was approximately 12 months. The patients were discharged at the end of this period and advised to take additional chemotherapy for another six months, for an average of 18 months of total therapy. One hundred of the 105 patients were discharged as fit for military duty. Five were placed on temporary retirement, two for administrative reasons. Two of these patients, although unfit for military duty, were capable of living in the general community under reasonably normal conditions as their limitations were imposed by pulmonary insufficiency rather than pulmonary tuberculosis. Thus, in none of the patients was the tuberculous disease considered a disabling factor at the time of discharge.

The only harmful effects noted in the entire group were due to accidents during competitive sports—two received fractures.

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
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Such striking antidiarrheal activity strongly suggests that Lomotil is the drug of *first* choice for prompt and positive control of diarrhea.

Dosage: The recommended initial dosage for adults is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. of atropine sulfate to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

An exempt preparation under Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' Product Brochure No. 81 from G. D. Searle & Co., P.O. Box 5110, Chicago 80, Illinois.

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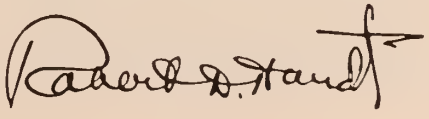
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References:

[1]Bastian, J. W.: Classification of CNS Drugs by a Mouse Screening Battery. To be published in Intern. Arch. de Pharmacodynamie; [2]Hubata, J. A., and Hecht, R. A.: Review of Clinical Use of Hydroxyphenamate (Listica) in 1,759 Patients. To be published in Clinical Medicine; [3]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [4]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). *Ibid;* [5]Davis, O. F.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. To be published; [6]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept., 1961; [7]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. *Ibid;* [8]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. *Ibid;* [9]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). *Ibid;* [10]Friedman, A. P.: Pharmacological Approach to Treatment of Headache. *Ibid;* [11]Greenspan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. *Ibid;* [12]Gouldman, C., Lunde, F., and Davis, J.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. *Ibid;* [13]McLaughlin, B. E., Harris, J., and Ryan, E.: Double Blind Study Involving "Listica," Chlordiazepoxide, and "Placebo" as Adjunct to Supportive Psychotherapy in Psychiatric Clinic. *Ibid;* [14]Bastian, J. W.: Pharmacology and Toxicology of Hydroxyphenamate. *Ibid;* [15]Bossinger, C. D.: Chemistry of Hydroxyphenamate. *Ibid.*

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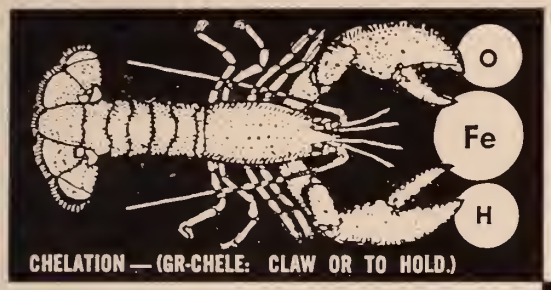
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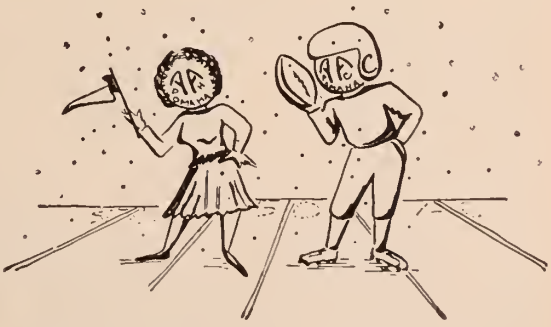
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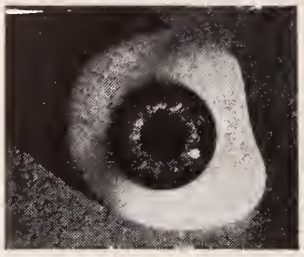
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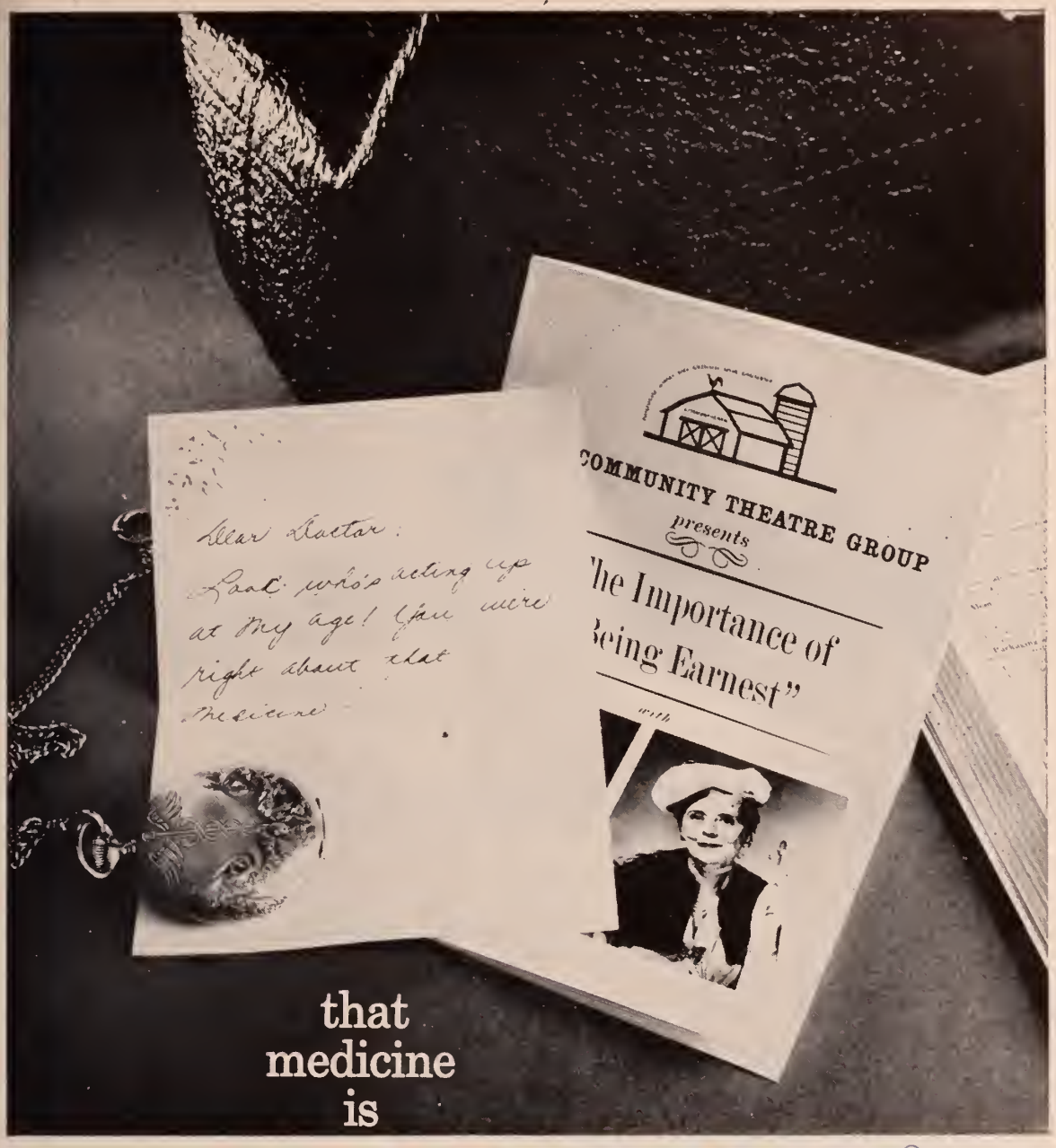
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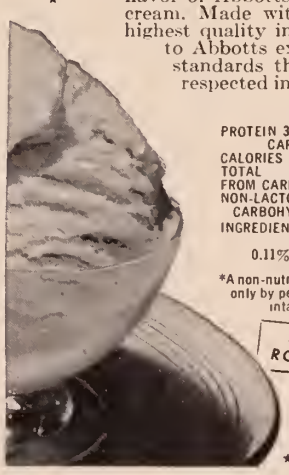
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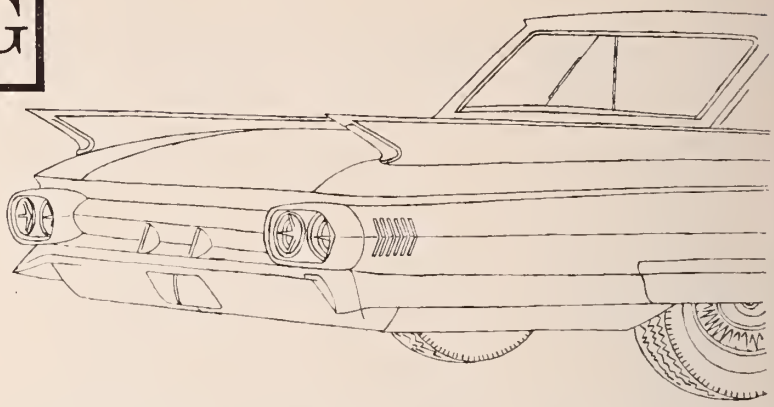
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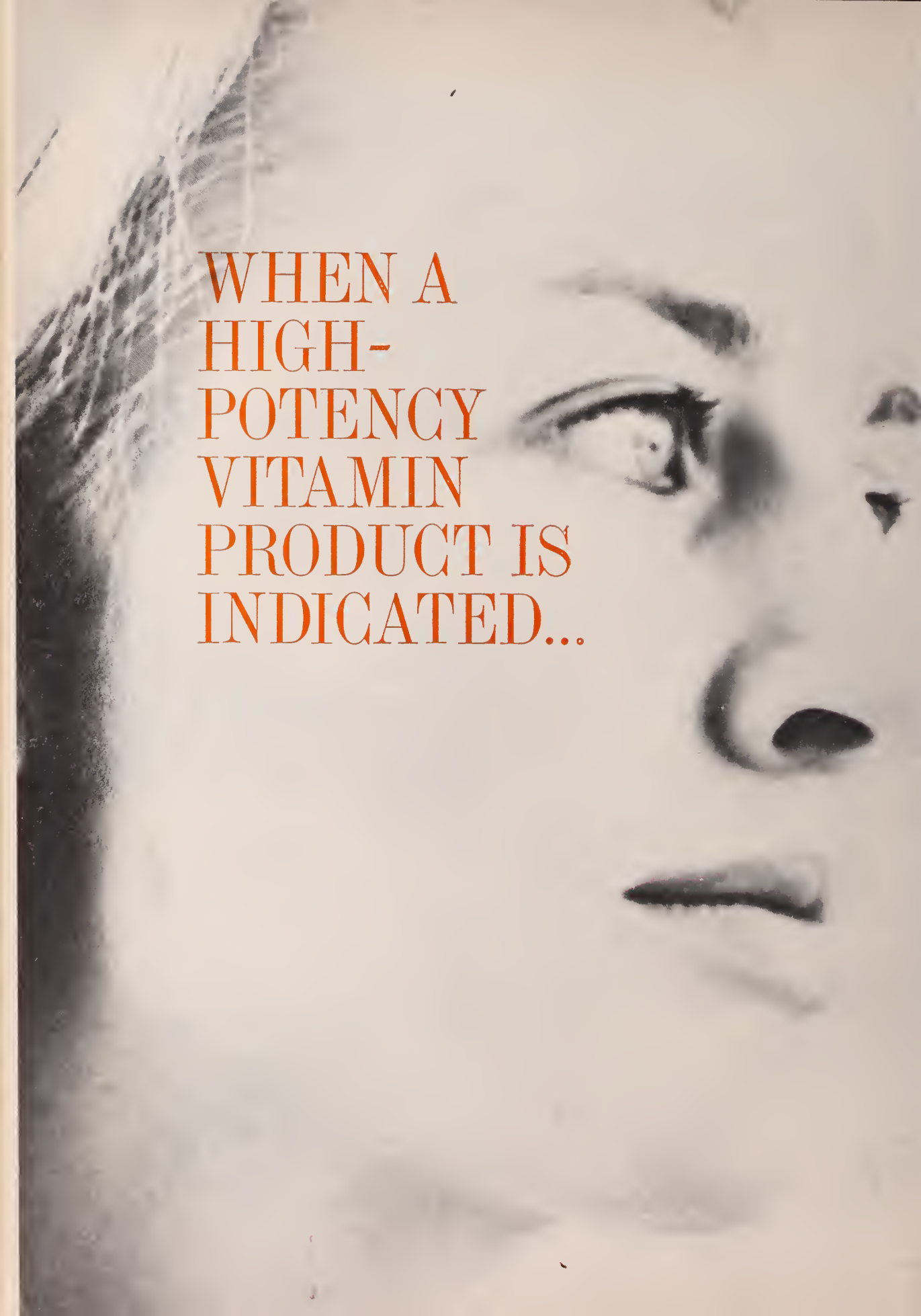
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Second Class Postage Paid at Orange, N. J.

VOL. 58, NO. 12 DECEMBER, 1961 Subscriptions, $3.00 per year Single Copies, 30 Cents

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Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

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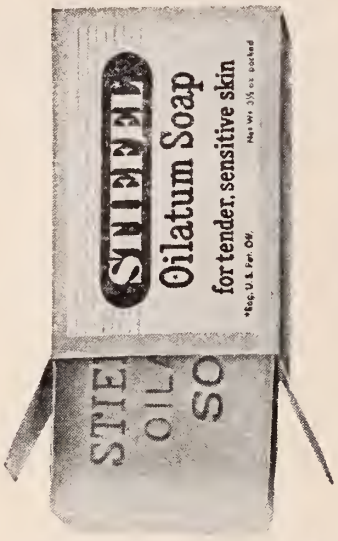
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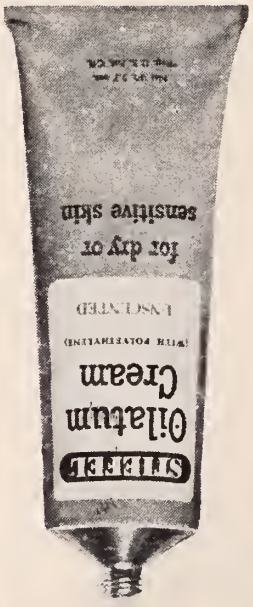
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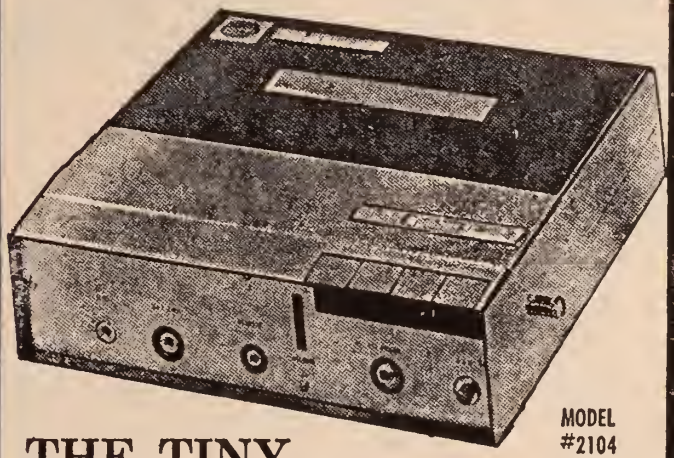
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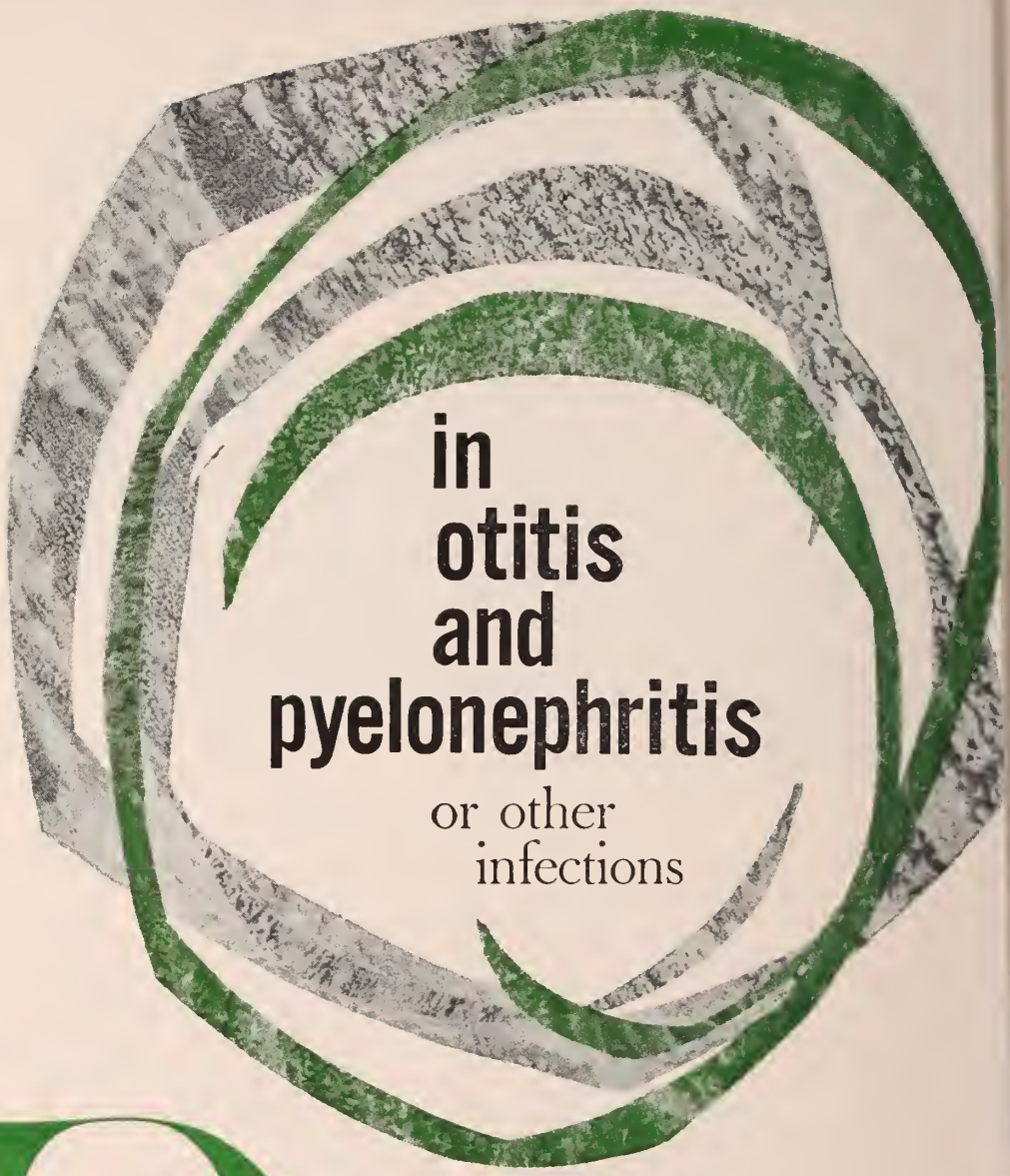
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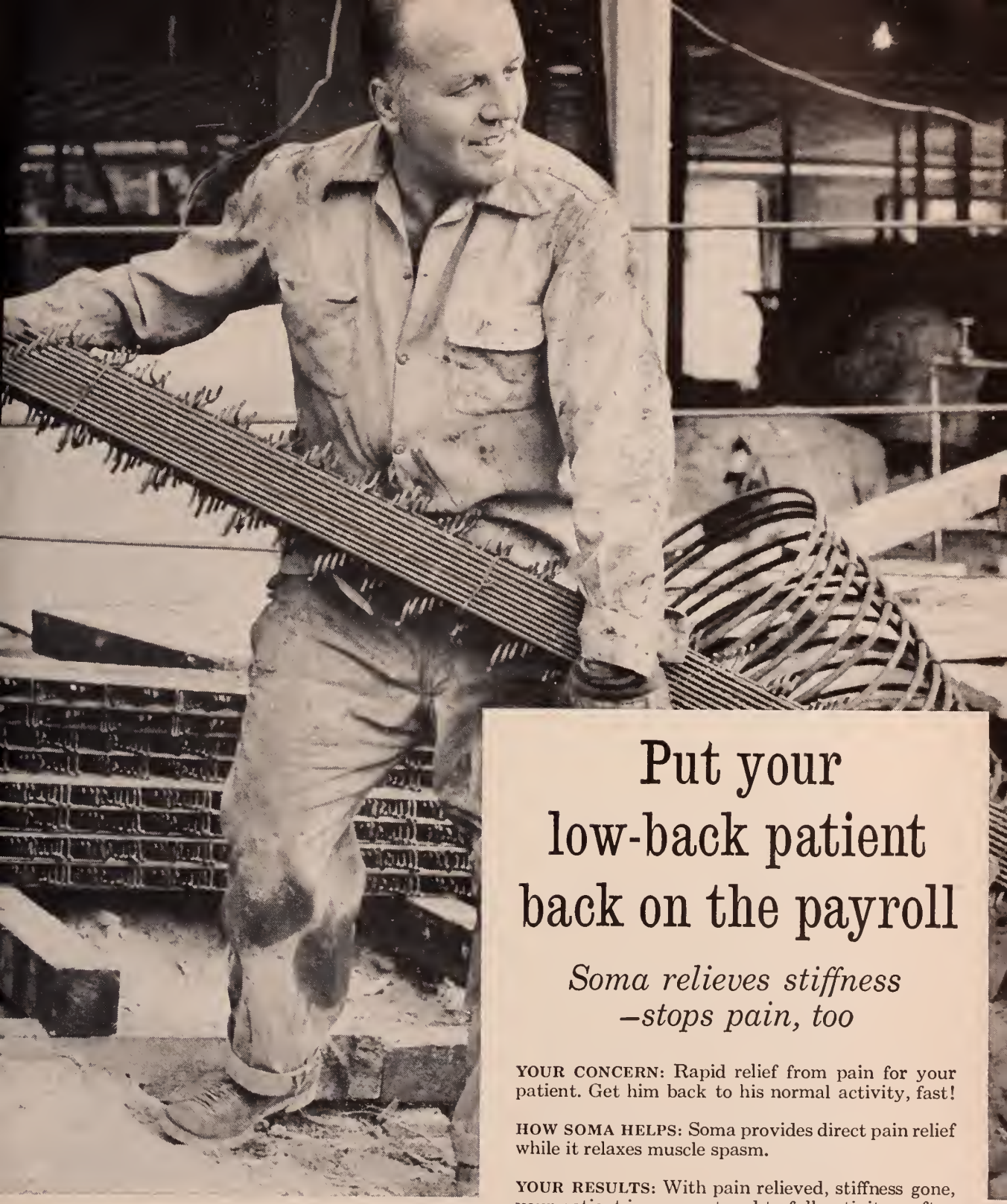
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MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
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(Continued on following page)

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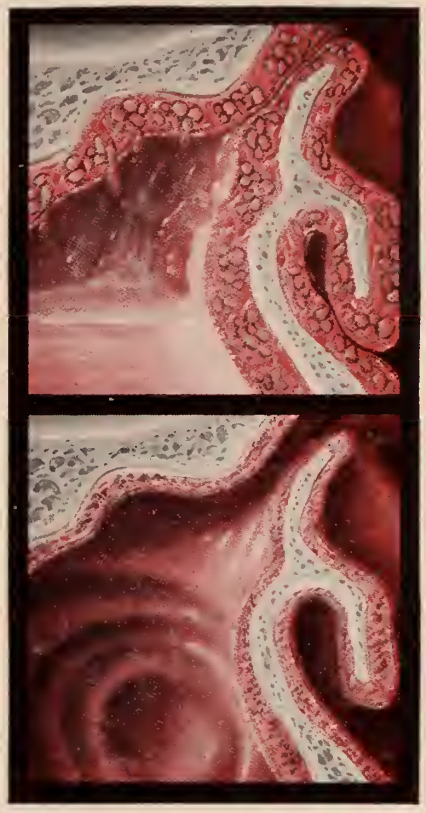
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(Continued from preceding page)

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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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1. Barden, F.W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R.A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Twentieth Century Quackery

Elsewhere in this issue* is a review of an atlas of nineteenth century quackery. As we look through the lurid and incredible advertising of those days, we smile at the credulity of Americans. Could anyone really believe that magical pain extractors would uproot pain, that magnetic oil would "cure" rheumatism, that Redwig's Mexican Joy Herbs would eliminate the symptoms and basic causes of twelve different diseases? How could a successful, prosperous, shrewd people—capable of building an empire—how could such a people fall for the arrant nonsense of these quacks? We are much smarter now in the mid-twentieth century.

But are we? There were Indian snake root peddlers a century ago. We have a new Indian snake root now—Asiatic Indian though, not American Indian. (That's the serpent in *Rauwolfia serpentina*). We have diet fads galore, and many a man who should know better rides a hobby to death. A book on folk medicine not so long ago was on the best seller list, though it seems incredible that anyone could have honestly believed that a mixture of two simple ingredients could have been such a panacea. We have had dianetics and Bridey Murphy, and a heart-breaking parade of cancer cures. Any night on television you can see simple medications portrayed as miracle drugs, with anatomic and physiologic sketches that make up in luridness what they lack in accuracy. Quackery is always with us, and we are, basically, no smarter than our grandparents. We may be more cynical, more skeptical and less concerned with such old-fashioned qualities as honor and morality. But we still want so much to believe that we will

*See page 619 for review of *One for a Man; Two for a Horse*. The curious reader is also referred to Curtis MacDougall's interesting book, *Hoaxes*, a second edition of which was published by Dover Publications, New York City, in 1958. An inexpensive, amusing, and thought-provoking book on a similar topic is *Fads and Fallacies in the Name of Science* by Martin Gardner, New York, 1957, Ballantine Books.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month

Whole Number of Issues 688

VOL. 58, NO. 12 DECEMBER, 1961 Subscriptions, $3.00 per year
Single Copies, 30 Cents

rationalize anything that fits our emotional needs or our dearest wishes. The fight against charlatanry has always been one of organized medicine's noblest claims to public confidence. The battle against quackery is not over. And as with all battles, eternal vigilance is needed.

Limits on the U. S. P.

The Pharmacopoeia performs an essential function in medical education, pharmacy, hospital operation, public health, and pharmaceutical manufacturing. Its unchallenged prestige results from: the integrity and eminence of its staff and of the personnel of The United States Pharmacopoeial Convention; from its position as our country's prime drug compendium; from its "official" status, conferred by Act of Congress; from its role as the basis for the requirements demanded for drugs by the Food and Drug Administration; and, in general, from its provision of the basic guidelines upon which reliable drug manufacturers build their standards for materials, processing, and stability.

The U. S. P. is not merely a book of standards, but, indeed, the *Blue Book* of "those drugs of established merit which are intended to reflect the best teaching and practice of medicine."

So, we yield to no one in our admiration for this veritable almanac of pharmacology. However, like all works of man, it has its limitations. For one thing, mere compliance with a U. S. P. monograph will not automatically guarantee a preparation of the highest quality any more than a literal following of a recipe in the finest cookbook will guarantee a culinary triumph if the housewife is a bad cook, or uses a dilapidated stove, unreliable measures, and poor utensils. Top quality demands, in addition to observance of U. S. P. specifications, skilled personnel of high integrity, expensive and complex equipment; and a laboriously worked out and individualized system of quality control for each particular preparation.

Therapeutic performance of a pharmaceutical product cannot be predicted solely by carrying out the applicable U. S. P. assay for determining the drug content. Almost all pharmaceutical products contain ingredients other than the active drug. The manufacture of these products involves mixing, compressing, coating, heating, filtering and so on. Any of these operations, if improperly controlled, may affect the therapeutic performance of the preparation even though the assay does not show deviation of the drug content from "official standards."

The U. S. P. cannot be a road-map to perfection. The objective of the U. S. P. is to establish standards and tolerances as a basis of sound practice—for range of weight variation of the active ingredient; for purity; for morphologic characteristics; and for disintegration time. These are essential standards, but their limitations on assuring or evaluating product quality and therapeutic efficacy must be recognized. Consequently, for many drug manufacturers—who stake their reputations on a degree of excellence "beyond the call of duty"—just meeting U. S. P. specifications is not quite enough.

The U. S. P. has never pretended to devise a quality control system for the manufacture of any drugs. Its restraint here is wise, for the setting up of any such system is a highly individualized matter, dictated by the conditions and technics prevailing in each manufacturing plant.

The unsophisticated layman asks: "Don't we have assurance of safety and efficacy if my doctor prescribes a preparation on the label

of which the manufacturer (or distributor) has imprinted 'U. S. P.' after the name of the drug?"

The answer is that there is *no guarantee* that it is effective. The manufacturer may actually use these initials without compliance with the U. S. P. specifications; or he may have gone through the motions, but performed the relevant tests and assays improperly. Unfortunately, in either case, he may get away with it—for the U. S. P. has no facilities for inspection (let alone enforcement), and the Food and Drug Administration can inspect only a tiny fraction of the products of more than a thousand drug manufacturers. In this connection, the World Health Organization, in a 1957 report says, "It is not anticipated that sufficient personnel will ever be available in even the most advanced countries to provide adequate service for the analysis of every batch of the preparations sold. It is impossible for complete laboratory control to be exercised by the official laboratories."

The U. S. P. is an indispensable book and, above all, a *practical book*. Its objectives can be realized to the full only by the drug manufacturer who knows *what* should be done, and who devotes much more than a grudging minimum—in time, effort and money—to doing it. This manufacturer's products will not only conform to the letter of the U. S. P. specifications, but, more important, will fulfill the primary *intent* of these specifications. The legend "U. S. P." works no magic. It cannot exorcise dishonesty or incompetence in quality control.

Germs and Super Germs

It is the age-old struggle of the makers of arms versus the makers of armaments; the manufacturers of insecticides versus the adaptability of insects; the development of antibiotic and antiseptic medications versus the growing immunity of bacteria.

Take the insects for example. Pathogenic bacteria are, in a sense, insect pests. The reproductive capacity of insects is staggering. It is not unusual for 15 or 20 generations to breed within a single calendar year. Insects have a trick of developing an immunity to the poisons we dream up to destroy them. A recent study* indicates that some kind of super bug has been developed which can laugh at our newest insecticides. At the start of World War II, DDT became popular and in the early days of that war, DDT could kill tens of millions of flies. Not now, says this survey. "Today DDT and other chlorinated hydrocarbons are far less effective on flies and roaches than they were ten years ago." Insects, it appears, are growing tougher every year.

Insects develop this resistance in several ways. They learn how (if "learn" is the word) to store poisons in less essential parts of their bodies. They develop a technic (if you can call it a technic) of slowing down the absorption of toxic substances so that the dosage is reduced. Some have even learned how to produce an internal antidote—a process which has its analogue in human physiology.

So it is with viruses and pathogenic bacteria. We need never anticipate that we will develop such wonderful drugs that all disease-producing germs will be wiped out and all infectious diseases will disappear. Every bug has the potential of becoming a super bug and in the struggle against pathogenic organisms there is no end point.

*Reported by Shannon Kirby in *Pen* Magazine, April 1961.

JOHN L. TULLIS, M.D.

Summit

Radiations and Carcinogenesis*

That exposure to radiation may precipitate carcinoma is not a new observation. Too often, however, it is presented either in panic or in passive casualness. Dr. Tullis here offers a brief and objective analysis of the problem.

A FEW years after von Roentgen announced the discovery of x-rays, several observers[1] reported the development of malignant tumors in skin that had previously been exposed to large amounts of x-rays. Since then, many experiments and clinical observations have helped to establish the fact that ionizing radiations are carcinogenic. Given proper conditions of radiation exposure, neoplasms may be produced in almost any organ in a wide variety of species. In man the commonest radiation-induced cancers are those of skin, bone, and lungs; and the leukemias. Radiation is probably capable of inducing or helping to induce neoplasms in any human organ.[2]

Susceptibility to tumor induction varies among the species, strains, individuals, and organs. In addition to the variables in the host that influence carcinogenesis, the physical factors of the radiation further complicate the interpretation of biologic response to exposure. The size of the dose, the dose rate, the wave length, the energy, the mass and the electrical charge of the radiation all play some part in its effectiveness in eliciting a biologic response. For instance, soft x-rays are absorbed. They affect only the superficial layers of tissue to which they are applied. Hard x-rays, being of shorter wave length, penetrate into and transfer energy in the deeper layers of tissue. X-rays are electro-magnetic waves. They have no mass and no electrical charge. Neutrons are also without an electrical charge, but they have great energy and they are particulate. These physical characteristics cause neutrons to have a relative biologic effectiveness 7 to 10 times that of hard x-rays. Yet the qualitative effect of x-rays and neutrons and of other types of ionizing radiations is similar. If sufficient energy is absorbed in susceptible tissue, all are capable of inducing neoplasms.

The size of the dose and the dose rate influence the biologic response. It is sometimes difficult to determine how much radiation is sufficient to produce one or another end point. Biologic effects are particularly difficult to measure in the low dose range where it may be impossible to distinguish between a random or chance occurrence and one that is the result of radiation specifically. All radiation absorbed in living tissue has some biologic effect.[3] This is one of the reasons for the establishment of a maximum permissible dose for occupational exposure.[4] However, in some tissues, radiation damage is of greater physiologic significance than it is in others. In germinal epithelium, radiation damage is permanent and any further exposure is cumulative. All genetic damage may find its way into the common genetic pool of the total population and thus may become manifest in future generations. Until recently the dose-mutogenic effect relationship was thought to be not only linear, but to be independent of the dose rate.

*Read May 16, 1961, at the Section on Clinical Pathology, at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, N. J.

Now it has been demonstrated [5] that the frequency of radiation-induced mutations in certain germinal epithelium is dependent on dose rate in the lower dose range. In the higher dose range, the linear dose-response relationship is readily demonstrated for both mutation and cancer induction, but whether cancers can be produced by small amounts of radiation particularly at a prolonged rate of administration is debatable. It cannot be categorically stated that a single ionization event in a single cell is not capable of producing a neoplasm; but it seems extremely unlikely that such a sequence does actually occur.

It is difficult to determine whether there is a threshold dose of radiation which if exceeded results in the induction of neoplasms. In one study, Court, Brown and Doll [6] found that the incidence of leukemia among 13,352 patients who had been treated with extensive wide field x-ray therapy for ankylosing spondylitis was about 10 times the incidence in a healthy control population. Two patients in their study received doses to the spinal marrow below 500 roentgens, but the average dose was in the range of 1500 r. No really low doses were tested. They concluded that there is no evidence of the existence of a threshold dose of radiation below which no increase in incidence in leukemia can be expected. Brues,[7] on the other hand, makes a strong case for the greater probability of a nonlinear or threshold relation of dose and effect in human leukemogenesis by radiation. Many others [4,8,9,10,11] have argued for or against the existence of a threshold carcinogenic dose of radiation, but no conclusive experimental proof can be offered by the proponents of either theory.

Thus, there is difficulty in determining the etiology of neoplasms in patients who have received only small doses of radiation. Another perplexing feature in the development of radiation carcinogenesis is the characteristically long latent period between the exposure to radiation and the clinical manifestation of the neoplasm. This latent period may vary from a few to many years and during that time there may be little or no clinical manifestation of the developing lesion. In one case [12] of a radiation-induced skin tumor the latent period was 56 years. The latent period in the development of skin tumors is, on the average, from 25 to 30 years, but may be as short as 6 years. The induction time for leukemia is shorter than that of most other radiation neoplasms, the usual latent period being 4 to 6 years. Latent periods for some of the better-known radiation-induced tumors are listed below:

Average (years)		Range (years)
25 to 30	Skin	6 to 56
5 or 6	Leukemia [1]	2 to 10
17	Lung [2]	15 to 20
5 to 10	Bone [3]	5 to 10
24	Bone [4]	3 to 30
10	Thyroid	3 to 17
20	Nasopharynx	10 to 30
17	Thorotrast [5]	3 to 23

1. Following either large field therapeutic or atomic bomb radiation
2. Pitchblende miners of Bohemia and Saxony
3. Radium dial painters—ingestion of radium—mesothorium
4. Post-therapeutic administration of radium compounds
5. Variety of tumors following diagnostic thorotrast administration. See reference 21.

The voluminous literature dealing with radiation carcinogenesis has been adequately evaluated [12-21] in many reviews. In this paper only a few facets of the subject chosen because of their current interest are discussed. Some of the more general problems have been touched on above. Comments of a more specific nature follow.

In some localities in the United States it was (until recent years) common practice to irradiate the neck and chest of infants and children in an effort to reduce the size of the thymus. Doses were occasionally less than 200 roentgens, but were usually at least 200 r and sometimes were as high as 1500 r. In a study [22,23] of 1722 children in New York state, who had received thymic irradition in infancy, there was an increased incidence of cancer of all types. *The incidence of leukemia among the irradiated group was 10 times the expected number.* Actually 0.6 cases were expected in the control group, but none was

found. The studies were well publicized and the dangers of thymic radiation in children were emphasized. Since the average induction time for leukemia is 5 to 6 years and since the danger of radiation has been so well publicized, it is not likely that there will be many more cases of leukemia due to thymic irradiation.

No large numbers of any one kind of malignancy were found in the New York study.[22,23] There were seven, or possibly eight leukemias and they constituted the largest single group of malignancies in the population studied. Only six thyroid cancer cases were found in the same study. However, because the expected incidence was 0.08 cases in the population studied, the six cases of thyroid cancer represent an incidence 75 times that expected. Duffy and Fitzgerald[24] in 1950 suggested that radiation to the neck and chest in infancy might be a factor in the development of thyroid cancer in children. Since then many other cases[25–31] have been reported.

Rooney and Powell[31] cited ten new cases of carcinoma of the thyroid in children 17 years of age or younger. Seven of the ten had received x-ray therapy in infancy. The total number of reported cases of thyroid carcinoma occurring in children who had received radiation to the head, neck or chest was thus raised to 121, one-third of the total number of all the reported cases of thyroid cancer in children. This makes a convincing case for cause-and-effect relationship. Because the latent period is known to extend up to 17 years, some of these cases may not yet be clinically manifest. However, the incidence of radiation-induced thyroid cancers in children should now be diminishing due to more enlightened medical practice and the expiration of the latent period in children previously irradiated. Interestingly enough, radiation does not appear to be a factor in the development of carcinoma in the thyroid of adults.

Another study pointing up the relative sensitivity of fetuses and infants to radiation was that of Stewart, *et al.*[32,33] These investigators found that children who were exposed *in utero* to x-ray pelvimetry or a similar diagnostic procedure had double the normal risk of dying from cancer before the age of 10 years. It was concluded that there is a valid "causal" association between fetal or early infancy exposure to radiation and the development of childhood malignancies. Court, Brown, *et al.*[34] obtaining information about 39,000 children whose mothers had been irradiated while the children were *in utero* concluded that there was no proved correlation between the radiation and the development of leukemia. However, subsequent observations[35] allowing for a longer latent period revealed that although the incidence of leukemia was lower than expected in the younger children it was 70 per cent higher than expected in the older children. No firm conclusions can be reached from these studies, but they do serve to sound a note of caution. To avoid increasing the possibility of inducing leukemia or other malignancies in children, x-ray examinations of the abdomen and pelvis of pregnant women should be undertaken only when necessary and when clearly indicated.

A current radiation exposure problem that may prove to be of major significance is in the uranium mining industry in this country. The pitchblende miners of Bohemia and Saxony developed a high incidence of lung cancers after many years' exposure to the radioactive atmosphere of their poorly ventilated mines.[36,37,38] In this country there are some 700 uranium mines in nine western states, employing 5000 men. About one-third of the mines do not exceed the maximum permissible dose of radon in the atmosphere; but another third have concentrations up to ten times the recommended safety level and the remaining third exceed the recommended level by ten times or more.[39] By contrast, the concentration of radon in the air of the European mines was only about 5 times the present recommended safety level in this country. Uranium mining is a new industry in this country. In a study by the Public Health Service only 907 of 3317 miners who were included in the study had had 3 or more years' experience in the mines. There

were 44 deaths among the 907 men with three or more years' exposure. Five or 11.4 per cent of the 44 deaths were definitely attributable to lung cancer. This is 4.5 times the expected incidence in the general population. The Public Health Service together with other government agencies is endeavoring to delineate the facts and help control the environmental health hazard; but if the early trend is maintained the results of the long term study may be very discouraging.[40]

SUMMARY

RADIATIONS may be carcinogenic, given time, a susceptible host and a large enough dose. How small that dose may be and still produce cancer or whether there is a certain threshold dose below which cancer cannot be induced is not known. In the adult it would seem that doses in the order of 1000 to 2000 roentgens are required to cause induction of neoplasms. In fetuses and young children, less exposure is needed to produce tumors. As little as 200 roentgens delivered to the thymus in infancy may produce leukemia, thyroid cancer or other malignancy. There is some suggestion that as little as eight to twelve roentgens delivered to the abdomen of a pregnant woman may play some part in the development of leukemia in her offspring. Radiation-induced malignancies are characterized by a latent period of a few to many years' duration. In view of the difficulty in measuring small dose radiation effect, the propensity of tumors to develop after a long, often symptom-free latent period, and the present lack of understanding of the mechanisms of carcinogenesis, physicians should avoid the unnecessary use of x-rays particularly in young children and pregnant women. Further, they should be alerted to the possibility of radiation as an etiologic agent in patients with a malignant lesion that presents in an organ previously exposed to large amounts of radiation either therapeutically or in an industrial environment.

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A bibliographic list of 40 citations will be found in the author's reprints.

Life Expectancy

"Saving lives of children and young adults has made it possible for more persons to live to the age of 75, or 85 years and older. Persons who now reach the age of 65 years, however, do not have a much greater life expectancy than had those of the same age in 1900," according to C. C. Dauer, M.D., in the September 1961 issue of *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession.

"At present," according to Dr. Dauer, "the average remaining length of life at 65 is 14 years, as compared with 12 in 1900. At 75 the average is 8.7 years, as compared with 7.1 in 1900, and at age 85 it is 6.4, compared with 5.3 years in 1900. More people live to be 65, 75, and 85 years of age, but life expectancy at those ages has not changed materially. There is little indication that the life span (which should not be confused with life expectancy) has increased much during the past 60 years. Comparatively few live to be 100 years old, and the proportion who do is not likely to increase very much until it becomes possible to postpone the aging and degenerative changes that occur in man as his chronologic age advances."

VIRGINIA N. WILKING, M.D.

Jersey City

Approaches to Treatment of the Emotionally Disturbed Child*

In this brief presentation, Dr. Wilking offers us not a technic of child psychiatry but a sensible orientation to the problem.

THE Oxford Dictionary defines treatment as "dealing with a person with a view to the result." This use of the word limits the concept. The term *therapeutic* has been overworked and I am exercising my prerogative as a child psychiatrist to deal with the whole child—or as Kanner once said—"the corporeal container," and to show interest in treatment apart from psychotherapy which is concerned less with the container than the thing contained. In the "emotionally disturbed" child, something has gone wrong. Whether or not the disturbance is originally in the emotional sphere is unimportant. The important decisions treat with what has gone wrong and what to do. There are a multiplicity of causes and a multiplicity of answers. As we enjoy increasing insight into the nature of what has gone wrong for any single child, we develop an increasing awareness of what to do or what should be done. The problem is to develop an approach to treatment which is based on very basic attitudes. Something can go wrong early in childhood for a variety of causes and with a variety of results; it may be physical, emotional, intellectual, or, sometimes even more devastating—social. In many cases, something can be done. This fulfills the definition of "dealing with people with a view to results." The definition of goals or the results to be viewed is another problem.

As any community becomes more sophisticated in the facts of mental health, there seems to be a recapitulation of historical stages in the concern for disturbed children which is reflected in treatment approaches. New approaches are hopefully increasingly sophisticated although old approaches are sorted out and the successful treatment methods retained. As I review some of the more important approaches in chronologic order, we will have an opportunity to remember the variety available to us. The selection of facts is my own. Kanner has helped us think in decades, but the Muse of History must look sideways at me and not at Dr. Kanner as I select my own facts out of these decades.

Early in this century the social conscience of our country was reproached by the plight of various groups of children. Pressure was brought to bear on our collective conscience in different situations. Groups became concerned for groups—as a result of the concern and devotion of scholars, social workers, doctors and teachers. Labor leaders agitated for Child Labor laws. Clifford Beers spoke for the mentally ill in hospitals and the National Committee of Mental Hygiene was organized. Healy spoke for the delinquents he saw in the Illinois courts and there was group concern for the problems of delinquency. Here in New Jersey

*Paraphrased from a talk by Dr. Wilking, April 22, 1961 on the occasion of the second anniversary of the Tricounty Children's Center in Morristown. Dr. Wilking is Professor of Psychiatry, Chief, Division of Child Psychiatry at Seton Hall College of Medicine, Jersey City.

—at Vineland—Goddard studied the retarded and planned for their care. It was a time of sorting out and of sweeping plans; many problems were still unrecognized and it was a legitimate time for a first-things-first approach to treatment which still may be pertinent.

By the second decade of the century, life was already more complicated. The children would not stay in the proper piles. There was an increasing concern with causation which reflected the vast new knowledge of the unconscious and of the lost times of childhood—derived from experience with psychoanalysis and Sigmund Freud's early papers. The knowledge of individual interaction of child and parents at an early age was applied to and reflected in a new kind of child care. Foster home placement was considered for the child without family and even for the child with an incapable family. Treatment took the form of manipulation of the environment.

By the century's third decade, against the background of more and more experience in the direct treatment of adults, there was dissatisfaction with over-simplified attempts to manipulate the physical environment. It was felt necessary to resolve the children's internal conflicts and as a result there was an emergence of psychotherapy as an art. With further recognition of the importance of the emotional environment, the family's role in treatment was given due consideration. In 1919 there were only seven Child Guidance Clinics, but many more, including the Essex County Guidance Center,† were established in the 1920s. Here children were treated as individuals by the orthopsychiatric team of social worker, psychologist and psychiatrist against the background of work with the family. Parent-Teachers Associations, started at the same time, reflected an equal concern with the child's life at school, and the emotional environment of the schools was given thought.

In the 1930s the excitement of direct treatment of children was reflected in a body of experience related to psychotherapy: that is, a specific psychologic approach to psychologic problems. This experience was gained by many of the grandfathers and grandmothers of child psychiatry. Having mentioned the generation, I cannot mention names, except to say we all bring their knowledge to bear in the one-to-one relationship with a child—Levy, Kanner, Allen, Despert, *et al.* Treatment was carried on in residential treatment centers as well as in out-patient clinics. The stress on the internal, rather than the external economy shifted emphasis from the family and still further from the community, particularly in the face of in-patient treatment, and the too well known reality situation wavered like a mirage. In over-all terms, then, there was a diminution of interest in nonpsychologic and nonpsychiatric approaches. Some of the experience of the 1910s and 1920s, in recognizing the child deprived by nature of the socio-economic setting, the child in trouble because of the absence of parental figures, and even some of the early work in delinquency, was forgotten—but not for long. In the 1940s there was an increasing emphasis on integration of approaches. The family and the school and even the community were rediscovered. It was remembered we could not work in a vacuum. Frequently it was the children who reminded us by shifting emphasis. Treatment took more time as so many were involved; as those who work with children know, everyone is always on the telephone. The treatment scene was somewhat crowded at the start of "family therapy" and the therapist was often forced from behind his desk to the top of his desk. We gained experience in coming to terms with the less than perfect family setting as the father was often away in the armed forces.

In the 1950s there was re-emphasis of the medical role in treatment, with the continued use of drugs. Treatment clinics for children were increasingly aware of the medical aspects of community responsibilities which implied the need for a working relationship with community hospitals. The place of the medical schools and hospitals with training centers was re-emphasized. In Child Psychiatry, an Examining Board set up in 1959, underlined the need for a variety of experience, in

†Originally called the Essex County Juvenile Clinic, this pioneer New Jersey agency was the first tax-supported child guidance clinic in this hemisphere—Editor.

and out of the medical setting, involving an understanding of treatment approaches over and beyond individual psychotherapy. In New Jersey, the Beadleston Act provided a framework within which to consider the child at school and a stimulus towards working out specific educational technics.

In the 1960s—in the seventh decade of this century, we are in the happy position of having a clean slate and being in a corresponding state of innocence. If we use the experience of the past and rely on our own wits for the future, we have a great deal at hand.

I would give a certain priority to the things to be done. First, we must learn more about the *normal* child and the best ways in which to alert parents, schools and communities to real danger signals. We should learn to distinguish specific and pathologic reactions to specific threats from the complicated condition of being alive.

We must learn to accept the fact of continued expectations of feelings of pain and pleasure, guilt and anxiety as part of the condition of being alive—for ourselves and our children. We must differentiate in this way between what is pathologic and what is not. In addition, we have to accept the evidence of our eyes that certain families are actually in good mental health balance. And we should learn to be more tolerant of the different aims which different families and different communities have for their children.

When the child and not the time is out of joint, whether the specific problems relate to his internal or external organization, we have to learn to make wise decisions in terms of proper approaches to his treatment. We must learn to use what we have while avoiding an inappropriate insistence on our particular approaches. We must learn to keep our own biographies in hand as we choose between camps, schools, residential treatment centers, clinics, medical and non-medical treatment.

We should learn to be exact about our goals. There are limits in what we can do. We cannot yet restore certain children to a normal level of intellectual function. We cannot make up for certain emotional deficits once they have been shown to be irreversible. We cannot convert all the anger of a child, grossly mistreated by family and society, into love. We have to accept our limits. We must decide, each in his or her own area, what we can do—and do it.

We can plan our treatment only if we know, not what we *want* for a child, but what they *need*. Thus we come back to the necessity for research of all sorts to help determine the necessary and the essential. Inherent in the idea of treatment is the movement toward a *result;* and we must have our goals clearly in mind as treatment is started. One of the most important tasks lies in education, much of it adult education, some of it self-education. However, in some areas, further education is impossible until research has been done and the facts are at hand.

As we make every effort to hold the line for children at home, in their schools—in their community, and even in their own states, we must have everyone's cooperation. Compassion is essential; but sloppy sympathy is not. We must be accepting and we cannot "run scared" because of our reservations about being brought face to face with disturbance in children or in adults. On the other hand, our own guilt should not drive us into "he is only a child"—or "it was only a little fire." Those who become over-identified with children can fail a child by failing to recognize pathology. I remember one child with 3 years of anecdotal records from a school. He had scrawled, crowed, caterwauled his way through three grades with little benefit to himself and none to anyone else.

Having outlined plans for elysium, I can only point to the Tri-County Children's Center and its intelligent attempts to help a specific group of children in a specific way. Here we are demanding much of the community, something of the child, much of the foster parents, much of the social worker and the Medical Director. One goal, exemplified by their program can be representative; the dictionary uses treat in a sentence "treat—as in 'treat me as a child'."

The Seton Hall College of Medicine and Dentistry

Frank L. Rosen, M.D.
Maplewood

Air Pollution, Meteorology and the Allergic Patient*

The air, says Dr. Rosen, "is a giant open sewer; it is time we paid some attention to the garbage we spew into it." Check, double-check, and here is how.

Air pollution, a major peril to all of us, is a far greater threat to the allergic person. The average man may cough for a few minutes after breathing polluted air; the hyper-sensitive one may react with an attack of bronchial asthma severe enough to put him in the hospital.

Allergic people develop allergies to substances which exist in their immediate environment. The higher the amount of ragweed pollen in the air in August and September, the greater the number of sufferers from hay fever and asthma. For example, soldiers in the South Pacific [25] who were in contact with grass pollen developed more allergy to grass pollen than soldiers stationed in this country, where ragweed is the predominant pollen cause of allergy.

Allergic patients are more susceptible to changes in weather, and changing weather factors themselves may induce asthma without the existence of any air pollution problem.[26] When a combination of both factors occurs; for example, a stationary weather front and air pollution, then allergic patients are hit much harder than the general population.

THE ELIZABETH-LINDEN INCIDENT

On November 18, 1953, public health engineers of the State Health Department were sent to the Linden-Elizabeth area of New Jersey to investigate a dense smog condition. They found sulfur dioxide aldehyde and other contaminants in higher concentration than usual.[27] The weather was abnormal for that time of the year. The Fahrenheit temperature ranged from 41 to 72—which was 13 degrees warmer than usual. The wind had died down to 2 or 3 miles per hour from an average of 6 to 10 the preceding few days. A steep temperature inversion was noted at 7:30 a.m., with a ceiling of 600 feet or lower. Temperature inversion [21] occurs when a layer of warmer air sits over a layer of cooler air, acting like a lid on a pot, preventing the upward escape of pollutants. Pollutants accumulate sometimes day after day. This unusual warm weather, with low velocity southwest winds, persisted for three days. During this period I treated fifty patients from this area with asthma and bronchitis instead of the expected ten to fifteen. Other physicians also reported a much greater incidence of patients from the Linden-Elizabeth area with acute respiratory distress. Local pharmacists had many requests for eye drops or special glasses to reduce eye irritation.

YOKOHAMA ASTHMA

Huber, *et al.*[28] describe a severe and recurrent asthma in patients with no previous res-

*Read May 17, 1961, before the joint assembly of the sections on allergy and chest diseases at the Annual Meeting of The Medical Society of New Jersey.

piratory difficulties. The syndrome, first observed at Yokohama, Japan, commonly occurs during smog in harbor areas surrounded by hills and in manufacturing areas. It is most common during the fall and early winter months. The initial symptom is bronchitis with subsequent dyspnea, usually occurring in the early morning. Dyspnea may become severe enough to necessitate permanent evacuation from the offending area. Allergens and inhalants of an allergic type rarely cause the disease. Skin reactions to allergic agents are negative. Air pollution by smog and such contaminants as ether-soluble aerosols and dust is apparently the primary cause.

THE WEIRTON INCIDENT

THERE was an episode in Weirton, Pa., in which fifteen persons were hospitalized as the result of inhaling carbon monoxide gas from the nearby steel plant. The gas was concentrated more than usual due to a temperature inversion.[21]

THE BRISBANE INCIDENT

IN AN article refreshingly titled, "It Happened One Night," Morrison[3] noted that many patients in the Brisbane (Australia) area developed asthma on April 20, 1959. He questioned 92 of these patients. During the night there was no change in temperature, humidity or barometric pressure in the area. During this period, however, there was a change in the variation of temperature with height above the earth's surface. Meteorologic data showed a temperature inversion at 12,500 feet at 9 a.m., April 20, but the inversion level had dropped to 7,600 feet at 9 a.m., April 21. Air was trapped beneath the inversion and could not rise above that level to disperse its dust and other matter.

SAO PAULO ASTHMA

MENDES and Cintra report a severe epidemic which occurred in August 1952, in Bauru and Sao Paulo, Brazil.[24] The epidemic involved 150 persons, with nine deaths resulting early in its course. Located in Bauru is a large factory for the extraction of castor oil. Here the manufacturers introduced a new method of extraction of the oil with hexane. None of the patients (adults or children) worked in the factory, but all of them lived in the city. The epidemic was caused by some allergen in the air derived from the dust of castor bean. The epidemic subsided when it rained. When the day was clear and windy, new cases appeared in the districts of the city subjected to the wind from the direction of the factory. Some of the patients lived in Agudos, 15 kilometers away. The symptoms subsided as long as the patients remained in Agudos and reappeared as soon as they returned to Bauru. Some of the patients had the same experience four or five times. Cutaneous tests, passive transfer of the antibodies, and experimental reproduction of asthma were made in 30 patients with positive results. The epidemic subsided when the factory was temporarily closed by the government. It recurred at the reopening of the factory and handling of the material with the hexane method. The factory was permanently closed. No new cases were reported.

OTHER AIR POLLUTION EPISODES

IN BELGIUM'S Meuse Valley in 1930, in Donora, Penna., in 1948, and in London in 1952 and 1956, the nuisance turned killer. In each case a heavy fog settled over the area and did not lift; in each case, also, this phenomenon was produced by what meteorologists call a temperature inversion. And in each case the death dealing ingredients were smokes and other pollutants mingling with the fog and building up to intolerable concentrations.[11]

The Donora story is the most familiar to us, because it happened here. Twenty deaths were specifically attributed to the episode. Thousands of the city's residents were made ill, to a greater or less degree.

These incidents light up the relationship be-

tween meteorologic factors and air pollution. Manos [19] writes that:

"The issue common to all of these studies is the relation of sickness or death rates to the levels of air pollution at any one spot or time. Obviously such weather elements as wind speed and stability play a great part in the estimation of the levels of air pollution at specific places and times. In addition, if some correlation between a form of sickness or cause of death and air pollution is identified, there remains the problem of deciding what portion of this must be attributed to the weather changes which accompanied the pollution, rather than to the pollution itself. In the extreme case, both the physical impairment and the air pollution could be the results of meteorologic conditions with no relation whatsoever to each other. This accounts for the great interest recently generated in the effects upon health of such factors as temperature and humidity, and for the desire to determine the effects of these elements, singly or in combination, on the course of certain diseases and the life expectancy of disabled persons.

"The importance of meteorology in studying the dispersion and distribution of air pollutants has been recognized for some time, but the direct effect of weather on health has recently claimed increased attention from those engaged in air pollution research."

WHAT WE KNOW ABOUT AIR POLLUTION

AIR pollution causes losses in the United States [1] estimated at $1.5 billion to $11 billion a year.

We have taken great strides in other fields of preventive medicine. We are just beginning to grasp the air pollution problem. A public health pamphlet [11] on the subject states, "The impact of polluted air on our health appears to take two general forms.

"The first is more dramatic, better known, and, fortunately, rarer—the acute 'episode' resulting from a deadly combination of man-made pollution and extended periods of restricted air movement.

"The second is subtler, harder to observe and document, and very little understood—the cumulative effect of breathing polluted air over a period of years."

An editorial [13] in the *Journal* of the AMA points out:

"Today—the air contains hundreds of substances which were never intended to be inhaled. Some of these make us uncomfortable or ill and at times hasten the end of human beings. The chief air pollutants today are the oxides of nitrogen, the oxides of sulphur, the aldehydes, carbon monoxide, smoke, condensed fumes and organic vapors often referred to as hydrocarbons, of which there are said to be 200 in automobile exhaust fumes alone."

In some respects we are the cleanest people in the world. We bathe often with the finest soaps, use millions of dollars worth of deodorants lest our perspiration offend; yet the air we breathe is dirty.

The greatest experts in polluting the air are to be found in England, Christie [4] told a recent air pollution forum in Montreal. "In England, where atmospheric pollution is heavy, the incidence of chronic bronchitis and its complication is 20 to 50 times that in Scandinavia, where atmospheric pollution is light."

"The most important way in which air pollution [12] influences health is that it irritates and so may possibly damage membranous surfaces of the body."

THE ALLERGIC PATIENT AND AIR POLLUTION

THE allergic patient gets it from both barrels.

Not only is he sensitive to tiny concentrations of pollutants in the air, but he frequently responds to changes in the weather with symptoms.

In industrial medicine we see patients whose asthma attacks have been precipitated by minute concentrations of chemicals in the factory air. These triggered attacks often persist for years, causing untold headaches for the compensation courts. I am convinced, after practicing Allergy for twenty-five years, that many asthmatics are wrongly labeled psychosomatic, when their trouble is actually coming from polluted air. Studies are now going on in California and Nashville to determine the effect of air pollution on bronchial asthma. Much more work is needed.

An air pollution Smoke Index Study [6] was conducted in New Jersey for one year (1956-7) by the State Health Department. (The smoke index is a rough guide to the degree of air pollution.) The least smoke was found in

Lakehurst, Sparta; and the most in Jersey City, Newark and Camden. From my own experience, I have noted a much higher incidence of asthma and emphysema in Newark, especially from the industrial section, than I found in patients from other nearby towns.

Says an editorial in the *Journal* of the AMA,[13] "The more parenchymal soot deposit, the more emphysema."

WEED CONTROL—AIR POLLUTION

THE allergic patient also has a problem with pollution of the air by pollens, chiefly ragweed in this part of the country. Meteorologic factors are just as important as the amount of pollen produced. The pollen is borne on the wind and its direction is of primary importance. For example, hay fever patients who live in shore areas do well on days with an ocean breeze, but with a land breeze their symptoms are the same as their inland brothers in distress.

Pollens can blow into a community from 100 miles distant. So local laws, even if they are strictly enforced, do comparatively little to cut down the amount of pollen in the air. Stronger national legislation is needed.

WHAT ARE WE DOING ABOUT IT?

"THE U. S. Public Health Service carries out three types of air-pollution activity: research, the training of personnel, and technical assistance to states and local governments which formally request such assistance. (*Note well: the Public Health Service cannot step into an air-pollution situation until it is requested to do so by local authorities.*)" On New Year's Day, 1957, the U. S. Public Health Service set up a network[7] consisting of 117 air sampling sites. There is one non-urban and at least one urban site in every state. Samples are mailed to the Taft Sanitary Engineering Center in Cincinnati. Air is collected by a modified vacuum cleaner drawn through a filter sheet of glass fibers.

A smog alert network[5] is being established in 36 states east of the Mississippi. The Public Health Service-Weather Bureau project will alert local weather stations from a weather research station at the PHS's Sanitary Engineering Center in Cincinnati.

On January 1, 1961, our own State's Air Pollution Code went into effect. Here is its opening sentence:

> No person shall cause, suffer, allow or permit to be emitted into the outdoor atmosphere substance in quantities which shall result in air pollution.

A survey has been going on in New Jersey for the past year by the State Health Department Air Sanitation program to determine the amounts of sulfur dioxide, oxides of nitrogen and ozone in the air. This program provides extensive consultative technical service to local boards of health with reference to complaints involving odors, dusts or particulate matter, property damage, and damage to vegetation.[20]

Activated carbon filters have been recommended[14] for use both at home and in the office by patients with severe emphysema residing in smoggy areas. Some new buildings in Los Angeles have air conditioning combined with air filtration over activated carbon to remove smog.

Chemical engineering can help. Sim and Pattle[18] report that adding magnesium oxide smoke or ammonia to an atmo phere containing sulfur dioxide removed the irritant and broncho-constrictive properties of that atmosphere.

WHAT CAN WE DO IN THE FUTURE?

AT A recent meeting of the Air Pollution Control Association, Dr. John D. Porterfield,[21] Deputy Surgeon General of the U. S. Public Health Service, stated that "We are closer to putting a man on the moon than we are to creating a thoroughly healthy and pleasant environment on this earth for man to live in—closer in know-how, closer in time, closer in probability of achievement."

We need laws with teeth in them, utilizing the knowledge we already have. A strong *national* law is urgently needed, since this problem is not confined to individual states or cities. Pollution originating in one area may affect neighboring states. Many towns and cities fear that industry will move to another state if there is strict enforcement of local ordinances. Thus, the New York *Times,* on February 17, 1961, reported on a new method of using pure oxygen in steel making. This results in more air pollution unless accompanied by effective but expensive smoke controlled devices. Some companies have dropped broad hints that they might transfer their facilities elsewhere if their modernization efforts are frustrated.

Baity [17] writes, "It is certain, that, on the basis of existing knowledge, much pollution can be avoided at a reasonable cost by careful planning and siting of factories and dwellings, better design of equipment, and better operation based on adequate training of management and employees."

Laws of the Soviet Union [16] now forbid the construction of new industrial plants without purification of discharge into the atmosphere!

WE NEED MONEY

An advisory committee to the Surgeon General of the Public Health Service has recommended [7] that financial support of air pollution research be increased from a current estimated level of $11 million annually to $32 million a year by 1968. Their number one goal for the next 10 years is to determine the effects of air pollution on human health. The seriousness of this problem would call for 10 times this amount.

Thomas B. Merrill,[21] an editor of *Business Week,* had this to say in a symposium on the economic and social effects of air pollution:

> . . ."nobody is going to put in any kind of control devices that cost him money unless he has to . . . There must be sanctions against industry or else it is going to pollute the air. These sanctions can be of many types. It simply has to be unprofitable for an industry to pollute the air or else they are going to pollute it, because it is cheaper to use the air for a sewer than to pay for keeping it clean."

COMBINED RESEARCH STUDIES

We need combined research studies with the Sanitary Engineers, the meteorologist and the physician. We need many more reports like "The Air Over Louisville"[8] and more postgraduate courses like those at the Robert A. Taft Sanitary Engineering Center in Cincinnati. Fourteen universities were offering graduate courses [13] on air pollution in 1959. We need ten times that number.

Dr. J. H. Foulger,[23] Director of Medical Research for du Pont (Wilmington, Delaware) suggests avoidance of venting irritating gases into the atmosphere during meteorologic conditions which might result in a fog.

PUBLIC EDUCATION

The menace of air pollution is great. Most people consider it no more than a minor annoyance, like an unusual irritating odor or a larger laundry bill. We are much more disturbed by local sewage problems or smoking and cancer. (One can give up smoking, but can't give up breathing polluted air.)

Our cars must be equipped to make exhaust products innocuous, regardless of cost. We must plant more trees in industrial areas to help restore oxygen to the atmosphere. Old methods of leaf burning must be changed. New ways of polluting the air must be recognized. We are paying a high price in air pollution for progress. For example, "The take-off of one commercial jet liner has been estimated to create a quantity of air pollution equivalent to that produced by 6,850 passenger cars."[15]

And as for the cars themselves, during New York City's unprecedented ban on non-essential vehicles during the February 1961 blizzard, air pollution dramatically dropped 66 per cent.[29]

Some cities have started drives like "Clean

Air Week." The State Health Department recently stationed a truck in front of the East Orange City Hall, which took samples of air for one week, while the public could observe a mannequin in a white uniform get dirtier each day. Other towns give awards and citations to industrial firms which help to diminish air pollution.

The air is a giant open sewer and since we have no choice but to breathe it, it's time we paid some attention to the garbage we spew into it.

2130 Millburn Avenue

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Communication by Detail Man

"In a poll of the nation's doctors sponsored by the American Medical Association, 68 per cent stated that the detail man was their chief source of product information. Since detail men are also our most costly means of communication, we cannot rely on them entirely. It is the aim of pharmaceutical companies to spend *as little*, and not *as much*, as possible on the promotion of their products while still maintaining effective communication with the medical profession." — T. F. Davies Haines, President, Ciba Pharmaceutical Products, to Association of American Medical Colleges.

Myron J. Shapiro, M.D.

Irvington

Control of Bleeding in Tonsillo-Adenoidectomy*

Fatal hemorrhage is always tragic; it is doubly poignant when it follows a procedure which the family considers "minor" surgery. Dr. Shapiro offers some practical pointers on bleeding control. And, as he says, "a noisy larynx is preferable to a silent heart."

The major problem in tonsillectomy and adenoidectomy is bleeding. When we examine what we do, and the surgical principles we transgress, the surprising thing is that bleeding is not more common. The average blood loss for this type of surgery is considerable and yet it is still classed as minor surgery. Troublesome bleeding may occur at surgery, immediately postoperatively, and in the late postoperative period.

What can we do about it? First, we can cut down the number of patients. More stringent indications for tonsillectomy and adenoidectomy are needed. We should not hesitate to do adenoidectomy alone, if that is all that is indicated.

PREVENTION

Reliance on bleeding and coagulation times as a screening method is valueless and should be discarded. Simpler, and more reliable are a history of bleeding or easy bruising, a family history of bleeding, and a low hemoglobin. Any, or all, of these should alert the surgeon to the necessity for a complete hemogram. Only a very small proportion of bleeding can be attributed to abnormal mechanisms and so we must look elsewhere for preventable factors.

Often the surgeon, knowingly or unknowingly, performs surgery in the face of unresolved local inflammation and hyperemia. This is particularly true if antibiotics have been used and are masking infection. Here is our main source of trouble. At Martland Medical Center, a municipal hospital for the indigent, the incidence of bleeding both at the time of surgery and postoperatively is very low. Most of the tonsillo-adenoidectomies are done by the junior resident and by interns. Excellent technic is not the reason for the happy results. Why, then, the low bleeding rate? These patients are not given pre-operative vitamins C and K despite the possibility of vitamin deficiencies. The reasons are not obscure. Tonsillectomies are a chore at this hospital and any excuse to cancel a case is seized upon. A history of recent exposure to infection (let alone overt infection), any abnormality of physical examination or blood picture, or any temperature elevation, are considered valid reasons to cancel surgery. The patient population is not treated with antibiotics pre-operatively so that masked infections are not a problem. If we carried that

*Presented May 16, 1961 before the joint assembly of the sections on anesthesia, otolaryngology and surgery of The Medical Society of New Jersey.

same attitude over to private cases, our incidents of bleeding would be less.

Many drugs available are supposed to control surgical bleeding. These drugs, it is said, reduce capillary bleeding. Actually, however, troublesome bleeding is rarely due to this. So many other factors must be taken into account that the value of these drugs must be questioned. Certainly a comparison of bleeding incidence 20 years ago and that of today, shows very little difference despite the use of vitamin C, vitamin K, Adrenochrome®, Premarin®, Koagmine® and Rutin®, just to mention a few. The effects of aspirin on prothrombin time are well known.

OPERATIVE BLEEDING

TONSILLAR bleeding is not as troublesome as adenoid bleeding because the fossae are available for inspection and instrumentation without too much difficulty. Bleeding points should be identified and ligated. Reliance on compression may leave a dry field but with postoperative retching, venous pressure is raised. Collapsed veins may bleed again. I try to make the fossa bleed before I am satisfied. Adequate exposure and illumination of the entire fossa is important.

Adenoid bleeding is more troublesome. Suturing or ligation of the bleeding points is the method of choice. With palate retractors (I prefer the Latrobe type) the adenoid bed can be exposed almost completely, depending on the shape of the nasopharynx. This allows more complete adenoid removal as well as bleeding control. However, some areas are not available for ligation or suturing, at least in my hands. Under these circumstances an orotracheal tube gets in the way.

If bleeding from the adenoid persists, a postnasal pack should be used. This is not a stigma of poor surgery; it is really our most important means of control of adenoid bleeding. A postnasal pack should be properly fitted and properly placed and should be tailored to size. I prefer compressed cotton packs because there is less trauma in their removal. Anterior packing, against the posterior pack, provides additional hemostasis. Use antibiotics to avoid middle ear and nasal infections.

I have used various local procedures including local infiltration with epinephrine, Gel Foam® packs, astringent pastes, Cornish yarn, lamb's wool packs, cotton packs, topical vasoconstrictors, and chemical cautery; but I have never felt as secure as when I have controlled bleeding by ligatures or posterior packs. If a good non-explosive anesthetic agent can be developed I am sure electrocoagulation would add a great deal.

IMMEDIATE POSTOPERATIVE BLEEDING

IMMEDIATE postoperative bleeding occurs within the first 12 hours. A recovery room with trained personnel is the best insurance against exsanguinating hemorrhage. Covert bleeding is sometimes difficult to recognize and children who are seen to be swallowing frequently (especially those who appear to be nasally obstructed) should be considered to be bleeding until proved otherwise. Too often, the first indication is vomiting of copious amounts of swallowed blood. Prompt operative control of the bleeding should be done without the delays of trying the so-called hemostatic drugs.

In these cases I use no anesthesia except perhaps sedation and topical preparations. The stomach is always full of blood and the danger of aspiration is too great for general anesthesia. A good suction pump is essential. Give fluids parenterally or blood if needed. Children can go into shock quickly and a rough estimate of blood loss is the best index of the need for replacement.

LATE POSTOPERATIVE BLEEDING

LATE postoperative bleeding most commonly occurs on the fifth, sixth or seventh postoperative day but may occur any time until the operative areas have healed. Abnormal bleeding and clotting mechanisms are not a

part of this problem, except inasmuch as dietary intake is always poor. Bleeding may be from granulation tissue or from separation of slough involving a larger vessel, more commonly the former. Repeated or persistent small hemorrhages are common and considerable blood can be lost, usually swallowed. Carefully examine the child if there is any doubt. In patients who suffer persistent pain (especially if there is fever on the fourth or fifth day) bleeding is much more common. This is consistent with the idea that infection plays a large role in this type of bleeding. Other important factors are the amount of trauma inflicted at the time of surgery and the amount of raw surface left.

Theoretically, in these cases, hemostatic drugs should be valuable, since bleeding from granulation is usually capillary bleeding; but I have been disappointed all too often. Prompt operative control with packs, sutures or ligatures offers the safest solution. General anesthesia is hazardous. My only case of cardiac arrest in a tonsillo-adenoidectomy occurred where general anesthesia was being induced in an apprehensive child who actually drowned in vomited blood despite the fact that a suction machine was operating before induction was begun. I have, since, seen and heard of other similar cases. I, therefore, admonish you not to use general anesthesia. A noisy larynx is preferable to a silent heart.

22 Ball Street

Immunization and Medicare

In keeping with current medical management of pregnancy, immunization (parenterally administered) against poliomyelitis and influenza are authorized benefits under the Dependents' Medical Care Program. Subject to the limiting conditions stated below, these immunizations are considered, for the purposes of Medicare, to be a part of complete maternity care.

EFFECTIVE DATE

These benefits will be applicable to all physicians' claims paid by fiscal administrators on and after November 1, 1961 bearing a "From" date not earlier than March 1, 1961.

AUTHORIZED SERVICES

The attending physician will be reimbursed for his *cost* of poliomyelitis or influenza vaccine administered by injection to a dependent eligible to receive care from civilian sources under the Dependents' Medical Care Program when he determines that such immunizations are necessary for proper management of the *maternity* case. Separate payment is *not* authorized for professional services and other supplies furnished in the administration of the vaccines, since remuneration is included within the allowances for prenatal care.

ALLOWABLE CHARGES

Physicians' claims may be reimbursed for claimed cost of poliomyelitis or influenza vaccines when the services are for medical management of maternity care. However, the cost of the vaccine should be adequately justified. A charge of $1 per injection is considered reasonable cost of the vaccine; therefore, charges not in excess of $1 per injection, when claimed, may be paid without specific justification. When the claimed amount is in excess of $1 per injection, justification is necessary. Justification will include the manufacturer's name, the attending physician's cost and source of supply.

Historical Article • • •

ALFRED R. HENDERSON, M.D.
Asbury Park

Matthew Baillie 1761 - 1823. Author of the First Comprehensive Text and Atlas on Morbid Anatomy

In this delightful vignette, Dr. Henderson helps rescue from obscurity one of the giants of medical history.

OCTOBER 23, 1961, marked the uncelebrated and recondite two-hundredth anniversary of the birth of Matthew Baillie, the most celebrated London physician of his day. Pathologists have owed a debt of gratitude historically to this colleague for over a century and a half; this forebearer who fashioned morbid anatomy as an independent systematized science from the unassorted, unclassified, monstrous museums of his uncles, from the impractical and bulky volumes of Morgagni and from his own dissections and observations.

Time has rendered Matthew Baillie an almost forgotten figure in medical history. So fitting are Shakespeare's lines:[1]

"Time hath, my Lord, a wallet in his back,
Wherein he puts alms for oblivion,
A great-sized monster of ingratitude;
Those scraps are good deeds past which
are devour'd
As fast as they are made, forgot as soon
As done."



Plate 1. Matthew Baillie (1761-1823). Photo courtesy N. Y. Acad. Med. Library.

Every man who pioneered a byway or highway of our medical historical past deserves to be remembered; his works, his courage and his life's story should not be permitted to pass into oblivion.

Matthew Baillie was born in 1761 in the manse of Shots, Lanarkshire, Scotland, into

1. Shakespeare, W.: "Troilus and Cressida." Act III, Sc. III.

a family possessing two of the most famous zoological and medical names of all time, John and William Hunter. His mother was the sister of the Hunters. With two uncles of this calibre one could have predicted the ultimate professional fate of this only nephew. In spite of his father's wishes for him to follow in his divinity footsteps, young Baillie studied medicine at Oxford.

Holiday time from his regular studies found this precocious young student in the dissecting laboratory and museum of his Uncle William Hunter, who became more like a father to him. Baillie soon became expert in assisting the elder Hunter in making anatomic preparations and later in superintending these dissections and lecturing.

The Hunterian dissecting theatre and its collection of comparative and morbid anatomic specimens had become the most famous in all Europe, as were the lectures given at the Great Windmill Street School by William Hunter. This was a fitting beginning for a young man about to enter the practice of medicine, not only because of the influence of this most unusual exposure to background knowledge, but also because of the potential social and professional contacts made available to him through his influential uncles.

Indeed, to have acquired membership into the scientific societies and to have received an appointment at St. George's Hospital at 27 years of age would have been exceptionally difficult for anyone without such family intercedence. This does not, however, detract from Baillie's own innate talents and dogged perseverance, which remain as constant features of his character throughout his lifetime. He progressed so rapidly in his uncle's laboatory that within two years he was appointed a demonstrator and lecturer.

UPON the death of William Hunter in 1783, his associate Cruickshank and young Baillie continued the lectures at the Hunterian establishment with great success and in the famous Hunterian tradition until 1799. One of his pupils[2] said of him: "His style, though not eloquent, irresistibly commanded attention; he appeared clear, concise, and condensed and never at a loss for an appropriate word. He was always modest and unostentatious."

In London circles Baillie soon became known as the "doctor's doctor" and among his patients was the celebrated Dr. David Pitcairn. Upon Pitcairn's retirement from practice because of ill health, Baillie acquired the bulk of his patients. From this point on, his practice became an overwhelming chore that cost him an average of sixteen hours a day and ultimately his own health.

He married the daughter of the most important obstetrician in London. Dr. Thomas, it will be remembered, was the first to write upon the congenital effects of syphillis ("On The Snuffles In Infants"). This marriage earned for him many more referred patients. His was the largest practice in London at the turn of the century. He was consulted during George III's illness and in 1810 was made Physician to the King and offered a baronetry, which he refused. Drs. Heberden and Willis also attended the King during his final illness, giving rise to the following epigram:

"The King employed three doctors daily,
Willis, Heberden and Baillie;
All exceeding clever men,
Baillie, Willis, Heberden;
But doubtful which most sure to kill is,
Baillie, Heberden or Willis."

Baillie's approach to the practice of medicine was unique for his day and is one feature of the man which renders him qualified to protrude into posterity. This important feature was the adaptation of his earlier anatomic and pathological training to each patient confronting him. He would look at his clinical problems only with the analytical eye of the morbid anatomist; each sign and symptom had to be answered in terms of structural alteration.

This, as we know today, is a good way to look at a complaining patient; but in the days when treatment went no further than prescribing for each symptom, ignoring the underly-

2. Adams, W. H. D.: "The Healing Art." Vol. II. Ward and Downey, London, 1887.

ing patho-physiology, one can realize the clinical frustrations brought about within him. He once admitted: "I know better, perhaps, than any other man, from my knowledge of anatomy, how to discover a disease, but when I have done so, I do not know better how to cure it."

Baillie devoted almost all of his time and energy to medicine; he diverted little time to literary or other scientific pursuits. He seems to have felt a keen inferiority in the presence of other learned men which occasionally made him unjust in his judgment of professional brethren whose minds were of wider scope than his own. He once growled out epigrammatically concerning one of the most learned scholars of the Edinburgh faculty: "Gregory seems to me to know everything but physic." Gregory's retort was at least as true: "Baillie," he said, "knows nothing but physic."

BAILLIE seized every opportunity to examine diseased organs after death, and preserved detailed notes of his observations. Like his great uncles, he gradually accumulated a well-selected collection of specimens. In time, this collection illustrated almost every diseased alteration in the human body and ultimately became an important exhibit, as did his library, in the Royal College.

From this massive file of detailed notes and specimens evolved the most important reason for remembering Matthew Baillie. The work for which he became established for all time was his book: "The Morbid Anatomy of Some of the Most Important Parts of the Human Body" published in 1795. It was immediately translated into French and German. This little book was declared, "superior to any eulogium in my power to bestow" by Professor Soemmering and was perpetually cited by Meckel, the most distinguished anatomists in Europe.[3]

The most marvelous feature of this work was the fact that within 250 pages Baillie had organized a wealth of first-hand experience, both his own observations and some of his uncles'. This anatomico-pathologico-clinical material was so systematized and readable that any average practitioner of the day could readily consume its contents within a relatively short period, without wading through unimportant or unrelated sidetracking details and apply this written knowledge in the everyday diagnostic aspects of medical practice. A lesson to be learned by authors of every generation!

To be sure, there were texts on pathology and even catalogues of collections of morbid specimens before this. The Florentine, Anthony Beniveni, who has been called the father of pathology, published *De Abdictus* in 1507. This is regarded as the forerunner of Morgagni's *De Sedibus* and represents the first attempt to find the morbid seats of diseases. It was, at best, just a beginning and served to start others seeking after the anatomical alterations which could only be seen in the dissecting room.

This was followed by Jean Fernel's *Universa Medicina* which appeared in 1554. Part two of this work has become known as the first real text of pathology. The greatest physicians of the sixteenth and seventeenth centuries were those who made dissection an important part of their lives. That gallery included such lasting names as Eustachius, Oddi, Bottoni, Pare, Bonet, Vesalius and Rabelais, to name but a few. Malphigi added microscopy to the study of tissues and John Bohn is remembered for his explicit directions for the autopsy technic.

BY THE mid-eighteenth century it had become time for a great mind to show the causal relationship between the morbid changes uncovered and the disease site as presented by the patient. This great function was accomplished by Jean Baptiste Morgagni who, in his classic *De Sedibus et Causis Morborum*, demonstrated the new principle that for every anatomic change there was a change of function. "In these volumes, we can see the ana-

3. Gunther, R. T.: "Early Science in Oxford." Vol. XI. Oxford University Press, Oxford, 1937.

4. Ficarra, B. J.: "Essays on Historical Medicine." Froben, New York, 1948.

tomist and pathologist combining his special knowledge obtained in the dissection room with the bedside observations of the clinician."[4] *De Sedibus* was the culmination of a gradual evolution of pathologic anatomy as well as the beginning of a new concept to be developed further in the nineteenth and twentieth centuries. But, as great as this work was (and one might say that it was too great for its time) it was not to be found in the usual physician's library; it was too massive, too unwieldy, not adaptable or organized for clinical guidance; definitely not a work-a-day guide for the man at the clinical level. In Baillie's own words:[5] "The descriptions, too, of the principal diseased appearances, have been sometimes obscured by taking notice of smaller collateral circumstances, which had no connection with them, or the disease from whence they arose . . . these faults even too frequently occur in the stupendous works of Morgagni, *De Sedibus Morborum*, upon which, when considered in all its parts, it would be difficult to bestow too high praise; besides, the bulk of these very large collections, prevents them from being generally in the possession of practitioners, and renders them more difficult to consult."

The next logical step in the historical development of pathology would be to bring this mass of correlated autopsy and clinical experience into a codified, relatively simple version, applicable in the hands of the student and practitioner, giving him a visual picture of the mechanism or functional-anatomic derangements producing the symptoms of his patients. This new exposition of pathologic material was to be found for the first time in Baillie's text. Here is his greatest gift to his profession; here he arranges his pathologic material and knowledge into the first systematic text in pathology in any language and pathology becomes an independent science.[6]

Though brief, and covering only the major organ systems of the human body, this text is clearly and simply written and deals in simple language with the lesions most likely to present themselves to the practicing physician, but with occasional notes on rarer entities also.

A NUMBER of significant "firsts" find their way into print by these writing, gathered from both his own observations and the notes and specimens left by his illustrious uncles. In the second edition of this text, "rheumatism of the heart" was first recorded. David Pitcairn had apparently made the first observations and presented them to his colleagues as early as 1788, but had not published anything on the subject. Baillie's intimacy with Dr. Pitcairn (previously mentioned) exposed him to this unpublished finding which, when included among the text material in *The Morbid Anatomy* was credited to the rightful discoverer.

Baillie's was the first accurate description of gastric ulcer. He was the first to describe transposition of the great vessels. He observed and described dextrocardia with complete *situs inversus viscerum*.

He was sniffing around a science yet unborn; functional pathology or pathophysiology, when he stated:[7] "There are some diseases which consist only of morbid actions, but which do not produce any change in the structure of parts; these do not admit of anatomical inquiry after death."

In Baillie's day, death was still often ascribed to obstruction of the heart chambers or mouths of the great vessels by "polyps." He takes issue[8] with this notion, declaring "They (polyps) . . . consist of a mass of the coagulable lymph filling up some of the large cavities of the heart . . . and have undoubtedly taken place *after* death. When polypi are examined, there is the same sort of appearance through their whole substance, which shows that the whole coagulum had been formed at the same time . . . which seems to contradict very strongly the opinion that polyps are formed during life."

His discussion of the functional pathology of ventricular aneurysm was the most plausible yet published. He expounds[9] upon the mech-

5. Baillie, M.: "The Morbid Anatomy of Some of the Most Important Parts of the Human Body." First American edition. Barber and Southwick, Albany, 1795.

6. Castiglioni, A.: "A History of Medicine." Knopf, New York, 1947.

7. Baillie, M.: Ibid. From the preface.

8. Baillie, M.: Ibid. Chapt. II, pg. 10.

anism of aortic arch aneurysm formation, explaining the fluid dynamic forces at work, in a very modern sense.

His description of aortic stenosis in a ten-year old boy may represent the first recorded case of congenital aortic stenosis. Unknowingly, within the same text, he describes the first case of sinus of Valsalva rupture.

BAILLIE discusses a case, previously related by William Hunter, *Medical Observations & Inquiries*, 1762, later becoming an entity called the Tetralogy of Fallot after Fallot's description in 1888. He carries the case further than his uncle when he described[10] the mechanism of cyanosis: "It is observed that in these deviations from the natural structure, too small a quantity of blood must pass through the lungs to receive the benefit of respiration, and this will be more or less according to the degree of the deviation. The blood will from this cause be of a dark colour, as it is well known that it receives the florid hue from the influence of air upon it in the lungs. Hence, the colour of the skin must be necessarily sallow or dark, and this will be increased when the blood is more than usual accumulated in the veins."

The first written account of inferior vena caval obliteration is found in this little masterpiece. An excellent description of the resultant dilatation of both azygos systems follows.

Another important publication of Baillie's was his article: *An Account of a Particular Change of Structure in the Human Ovarium.* This paper was communicated to the Royal College by his uncle John in 1789. He vividly describes the hair, teeth and bone found in the embryonic tumor of the ovary and denounces the belief of the day that these tumors resulted from a faulty pregnancy. As further proof of this he describes a 12-year old patient of his own, obviously not impregnated and another case of the celebrated Ruysch which occurred in the stomach of a man.

The supplementary atlas of pathologic illustrations, which accompanied later editions of the text, contained one of the first and most accurate illustrations of a specimen of pulmonary emphysema. The specimen, from his uncle's collection, has a further historical interest since it was the lung of Dr. Samuel Johnson, the lexicographer.[11]

In this same atlas is illustrated one of the earliest drawings of a hob-nailed liver to be found. His keen observing powers led him to remark: ". . . and it is commonly produced by a long habit of drinking spirituous liquors."

These are but samples of Baillie's contributions to morbid anatomy, and from the text which has been labeled[12] ". . . the first text of pathology devoted to that science exclusively by systematic arrangement and design."

In 1813, together with Eveard Home, John Hunter's brother-in-law, Baillie inaugurated the Hunterian Oration. This famous event in English medicine was to be delivered every year or two by an outstanding physician, invited to do so, to commemorate John Hunter's birthday and to keep his example before the on-coming generations.[13]

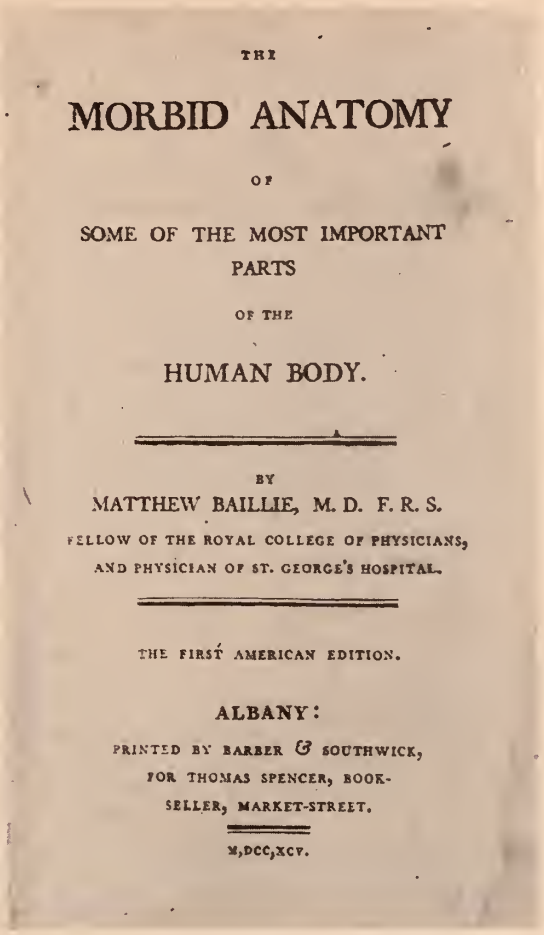
One cannot speak of Baillie's life without mentioning the almost legendary walking cane which he possessed and carried on occasion. This gold-headed cane was carried by four generations of England's greatest clinicians before him. Radcliffe, Mead, Askew and Pitcairn successively carried this symbol of medical authority which, upon Baillie's death, was presented to the Royal College by his widow. Inscribed upon the golden head are the coat of arms of each of these men. This article became the motive for a biographic work concerning the lives of these great doctors written by William Macmichael.[14]

In 1819, Baillie presented his entire anatomic collection, as well as his library, and a

9. Baillie, M.: Ibid. Chapt. II, pg. 16.
10. Baillie, M.: Ibid. Chapt. II, pg. 23.
11. Major, R.: "Classic Descriptions of Disease," C. C Thomas Co., Springfield, Ill., 1945.
12. Long, E. R.: "A History of Pathology." Williams and Wilkins, Baltimore, 1928.
13. Turner, G. G.: "The Hunterian Museum Yesterday and Tomorrow: The Hunterian Oration for 1945." Cassell, London, 1946.
14. Macmichael, W.: "The Gold-headed Cane." J. Murray, London, 1827.

sum of six hundred pounds, to maintain this life's work, to the Royal College. Most of the specimens were obtained by his own hands; some were gifts from professional friends and some were remnants of his great uncles' collections. Five editions of his great little text were published during his lifetime, with translations into several languages. The first American edition appeared in 1795, just two years after the first London edition. (Plate 2)

It has been said that Matthew Baillie could have become the great originator of the school of anatomico-clinical method had he devoted full-time to his laboratory and writing; but, unfortunately, perhaps, he was submerged by his practice and by the social impositions placed upon him and he did not succeed in propagating his ideas generally among the profession. Nevertheless, his little volume of morbid facts protruded further into posterity than did the excessive baggage of his predecessor Morgagni . . . recalling to mind the wise words of Voltaire in a letter to Damilaville in 1765: . . . "A twenty-volume encyclopedia will never cause a revolution; it is the little portable volumes of thirty sous that are to be feared. If the gospel had cost twelve hundred sesterces, the Christian religion would never have been established."


THE

MORBID ANATOMY

OF

SOME OF THE MOST IMPORTANT PARTS

OF THE

HUMAN BODY.

BY

MATTHEW BAILLIE, M. D. F. R. S.

FELLOW OF THE ROYAL COLLEGE OF PHYSICIANS, AND PHYSICIAN OF ST. GEORGE'S HOSPITAL.

THE FIRST AMERICAN EDITION.

ALBANY:

PRINTED BY BARBER & SOUTHWICK, FOR THOMAS SPENCER, BOOKSELLER, MARKET-STREET.

M,DCC,XCV.

Plate 2. Title page of first American Edition of Baillie's *Morbid Anatomy*, 1795.

501 Seventh Avenue

Physicians Form Wine Appreciation Society

Medical doctors in New York City have formed the Physicians Wine Appreciation Society. The group now meets regularly for educational lectures and wine tastings.

President of the Society is Herbert Gould, M.D. Dr. Donald Smith is vice president and Irene Hughes is secretary-treasurer. All are on the medical staff of Manhattan Eye, Ear and Throat Hospital.

Dr. Gould said that the Society was formed because many doctors are genuinely interested in furthering their knowledge about the wines of the world and their uses.

"We think our Society will offer physicians a great opportunity in this direction," he added.

Membership in the Physicians Wine Appreciation Society is restricted to physicians. Soon the Society hopes to become affiliated with medical groups in France which are dedicated to the appreciation and enjoyment of wines and spirits. For further information, write to Dr. Herbert Gould at 210 East 64 Street, New York City.

Announcements • • •

Symposium on Sterility

February 8, 9, and 10, 1962 are the dates for the next symposium on sterility in New York. Fashioned to meet the needs of internists, urologists, gynecologists and endocrinologists, this will consist of clinics, lectures, panels and demonstrations covering infertility in both sexes. This is sponsored by New York University and the American Society for the Study of Sterility. Tuition is $75. For more details, write to Graduate Medical School at 550 First Avenue, New York 16, N. Y.

Nutrition Seminar

All readers of this JOURNAL are welcome to attend a series of talks on nutrition to be held at Bergen Pines, Paramus, N. J., at 4 p.m. the first Monday of each month. The National Vitamin Foundation sponsors this colloquium, and a star-studded faculty has been recruited from New York and Philadelphia. The topics are:

January 8—Obesity
February 5—Folic Acid and Vitamin B-12
March 5—Ulcerative disorders
April 2—Renal disease as related to nutrition and metabolism
May 7—Pancreatic disease and diabetes

Further details may be obtained from Dr. A. I. Friedman at 405 State Street, Hackensack, N. J.

Center for Study of Whipple's Disease

Your cooperation is requested in a study of Whipple's disease now in progress at the National Institutes of Health, Bethesda, Maryland. This disease tends to occur in middle-aged males. In its fully expressed form it is characterized by arthritis, diarrhea, abdominal distention, cough, weight loss, and asthenia. The diagnosis is established by biopsies of peripheral lymph nodes or of intestinal mucosa, which reveal macrophages containing material that stains with the periodic acid-Schiff (P.A.S.) stain.

This study will investigate measures that are capable of producing remissions of this otherwise fatal disorder. It is hoped to gain insight into the mechanisms responsible for this strange disease. Patients are needed who have either sufficient circumstantial evidence to warrant suspecting this disorder or definite proof of the presence of the disease. Those who are admitted to the project will be evaluated to confirm the diagnosis and will be placed on regimens designed to produce remissions of their disease. The duration of a patient's stay will be determined primarily by the manner in which he responds to treatment.

Patients will then be returned to their referring physicians and complete summaries of the evaluations will be sent. Occasional follow-up visits supplement, rather than substitute for visits to the patients' personal physicians.

If you are interested in referring patients, write to:

LEONARD LASTER, M.D.
Senior Investigator,
National Institute of Metabolic Diseases, Bethesda 14, Maryland

Report Mycobacterial Infections, Please!

The State Health Department urges the careful reporting of all types of clinically diagnosed acid fast mycobacterial infections, whether due to Mycobacterium tuberculosis or to the presently unclassified types of acid fast mycobacteria.

Letters to The Journal • • •

Should Pharmacists Warn of Side-Effects?

What is the responsibility of the physician, the pharmacist and the manufacturer when a patient receives a prescription from his physician and has it filled at his pharmacy?

The following is a true story, except the names are changed. A medicine called Alpha tablets and Alpha time release capsules, made by the Beta Pharmaceutical Company, was prescribed by Dr. Jones for a Mr. Smith in 1959. Mr. Brown, the pharmacist, filled these prescriptions which had a refill notice that they could be refilled P.R.N. In the original package of these tablets there was an insert that stated that hepatitis might develop which would disappear when the drug was discontinued. These prescriptions were refilled only once, in 1959, and not since then.

In August 1961, the patient brought suit against the pharmacist and the manufacturer of the Alpha products, asserting that the medicine has given him hepatitis. He is not suing the physician. He suggests that the physician was *not* responsible because all he knew about the drug was what the detail man told him. He insists that it was the pharmacist who should have warned him that he might get hepatitis.

Since many new drugs can provoke side reactions, patients may be so frightened that they never would take the medicine that the physician ordered, if the pharmacist uttered such warnings. Of course, the druggist might properly warn a patient to take the prescribed medicine exactly as ordered by the physician, so that there would be no overdosage, or might advise him not to drive a car when taking drugs that might make him sleepy. But telling a patient that he might get hepatitis, or diabetes or a psychotic reaction is not a pharmacist's duty. Or is it?

With whom does the responsibility for side reactions lie? Presumably with the manufacturer who must fully inform the physician; and secondarily with the physician. The manufacturer is the creator of the medicine. The question then arises: has he warned the physician sufficiently of the possibilities of the side reactions? The physician, before he prescribes and uses a drug, is assumed to have learned all its actions and reactions. He is putting it to use. It is his responsibility and duty to be aware if any changes in the patient takes place; and to discontinue the drug immediately if this is necessary. What should the doctor tell the patient when he prescribes a drug that may have a dangerous side reaction? This I cannot tell. That is part of the job of being a physician. The pharmacist should *not* be held responsible for side reactions, he cannot follow the clinical progress of a patient.

—Jack Eisen, Ph.G.

Dear Editor:

Dr. Jack R. Karel's article in your October 1961 issue on "Doctors, Druggists and Turmoil," excellently states the facts about the abuses of prescribing drugs solely by trade-names. For the past thirty years of my medical practice, I have done practically all my drug prescribing by generic names. This means, that I study the U.S.P. and N. F. books, containing all generic names, which the local pharmacist lends me. As new drugs come out, I try to remember the generic names. If I can't remember a difficult generic name, I may use a trade-name, with "A.R.B." after it, meaning that I give permission to the druggist to dispense any *reliable* generic equivalent of that trade-name drug.

I have found it easier to remember a *single* generic-named drug, rather than burden my memory with a dozen or more trade-named drugs, for the identical product. Besides, as Dr. Karel so vividly pointed out, I consider that the local drug store has to earn a living, too, and if we prescribed by generic names, he would not have to stock duplications and reduplications of the same drug under various trade-names. In this way, I have always managed to keep the good will of the retail pharmacists in my community; and we are all happy about it. I hope that all practicing physicians follow this advice.

NAT KANNER, M.D.

Brooklyn, N. Y.

Dear Editor:

I have just read, with inspiration and interest, an article entitled, "Doctors, Druggists and Turmoil," in your October 1961 issue. Dr. Jack R. Karel, the author, has certainly done a masterful job of discussing the problem our pharmacists are faced with in the many duplications and combinations of pharmaceutical products being added to their shelves daily.

Believing this article to be of general interest to our pharmacist readers and feeling that it is Dr. Karel's hope to have as many people as possible read his timely discourse on this subject, I would like to reprint it in *Louisiana Pharmacist*, official journal of the Louisiana Pharmaceutical Association.

Please advise if we may have your permission to reprint the article referred to above and, if so, what you want in the way of a credit line.

Thanking you for your kind consideration of this request and awaiting your reply, I am,

Sincerely yours,

WILLIAM P. O'BRIEN,
Editor

Dear Doctor:

I was interested in your editorial in the August JOURNAL entitled "A Stench in the Ear." I agree that noise can be a health menace. However, some of the quotes in the editorial are open to question. The most definitive work done in the last few years, is by Karl D. Kryter. It appeared as a supplement to the 1950 Journal of Speech and Hearing Disorders. He writes:

"This survey shows nearly all industrial and laboratory experiments which report that noise adversely affects work output, are open to criticism because of poor experimentation and uncontrolled factors."

This statement applies to the work which you cited.

We ordinarily speak at a level of 50 to 60 decibels, so that 60 decibels of noise could hardly cause contraction of the muscle of the stomach wall unless it was a startle response to a totally unexpected sound. Damage risk criteria has been discussed fully by the American Standard Association and I refer you to their Z24 - X-2 report.

Noise can be harmful; it can be annoying; but it can hardly produce many of the biologic effects that have been blamed upon it.

HENRY Z. GOLDSTEIN, M.D.

Obituaries • • •

DR. FRANCIS N. CARBONE

More than a half-century of service to the people of Essex County came to an end on Columbus Day with the death of Dr. Francis N. Carbone. A 1910 graduate of the medical school of the University of Rome, Dr. Carbone came to the United States in 1911 and moved to Newark in 1913. He was a pioneer in dermatology, being one of the first New Jersey physicians to do graduate study in that field. He was particularly interested in metabolic disorders and was chief of that section at St. James Hospital in Newark. Dr. Carbone was a consultant in dermatology at the Essex County Hospital in Belleville. He was an FACP, and was active in the affairs of the Northern New Jersey Dermatological Society. He received the Selective Service Medal from President Truman in 1947 and the Golden Medal of Merit from The Medical Society of New Jersey in 1960. Dr. Carbone was 78 years old at the time of his death.

DR. STEPHEN CASAGRANDE

One of Monmouth County's best known physicians, Dr. Casagrande died of coronary thrombosis suddenly on October 7. Born in 1906, Dr. Casagrande received his M.D. at the University of

Virginia in 1932. After completing his internship in Roanoke, he became interested in pediatrics and had a two-year residency in that specialty in Kings County Hospital in Brooklyn. This led to a general interest in, and postgraduate study of cardiology, a field that was to hold Dr. Casagrande's attention for most of his professional life.

He moved to New Jersey in 1949 and served the people of Monmouth County ever since. In that brief 12-year period, Dr. Casagrande became director of internal medicine at the Riverview Hospital in Red Bank, co-director of electrocardiography there, Rumson police surgeon, Associate in Cardiology at the Monmouth Medical Center, a member of Riverview's Board of Governors, and an Executive Committeeman for Monmouth Memorial Hospital. Dr. Casagrande was one of the charter members of the American College of Cardiology.

DR. GUSTAV R. FARKAS

While on a vacation in the Swiss Alps, Dr. Gustav Farkas died suddenly on September 21. Born in Central Europe in 1899, Dr. Farkas was a 1924 graduate of the medical school of the University of Vienna. After interning in Vienna, he came to New Jersey and settled in Passaic in 1926. A general practitioner, Dr. Farkas had a particular interest in chest medicine, and was a Fellow of the American College of Chest Physicians. He was active in the affairs of the Passaic County Medical Society. He was affiliated on the medical service of both hospitals in Passaic.

DR. GERDA S. HILLYER

An accidental fall in London, England, led to the death of Dr. Gerda Sgalitzer Hillyer on October 11. Dr. Hillyer was in Europe with her husband, Rafael Hillyer, violist in the Juilliard String Quartet. The Quartet was on a European concert tour when the tragedy occurred. Dr. Hillyer, born in Vienna in 1913, received her M.D. degree at the University there in 1938. In 1940 she came to Boston to serve an internship at the New England Hospital for Women. She became interested in radiology, and did graduate work in that field at the Massachusetts Memorial Hospital during World War II. She taught radiology at the Boston University Medical School. When her husband became associated with the Juilliard School of Music, Dr. Hillyer moved to Bergen County, New Jersey and entered the field of cancer prevention, becoming affiliated with the Strang Clinic.

DR. HENRY J. MAJESKI

At the untimely age of 59, Dr. Henry Majeski died quietly in his sleep on October 3. Born in Trenton, Dr. Majeski was in the 1929 class of the Jefferson Medical College. He interned at St. Francis Hospital in Trenton, and did graduate work in orthopedics in Philadelphia. He was a Fellow of the American College of Surgeons and became Associate Orthopedist at St. Francis Hospital in Trenton. Dr. Majeski was the orthopedic consultant to the State Prison. Interested in medical journalism, he was active in the affairs of the New Jersey Medical Journal Club, and indeed, spent the last evening of his life at a meeting of that organization.

DR. JULIUS C. McKELVIE

On October 26, one of Monmouth County's best-known medical and civic figures died with the passing on that day of Dr. Julius C. McKelvie. Born in Georgia in 1887, he received his M.D. from Howard University in 1915. Dr. McKelvie was a general practitioner of the old school—a family doctor who took his civic duties seriously. For a full decade he was on the Long Branch Board of Education. In 1949 he was named State Chairman for the United Negro College Fund Campaign. He was an active member of the Monmouth County Committee for the Study of Juvenile Delinquency. He was the 1941 recipient of the Achievement Award for courageous public service given annually by the *Afro-American*. Dr. McKelvie was active in Boy Scout leadership work, and served some years as District Scout Committeeeman.

DR. WILLIAM HUGH MEIER

On October 23, a heart attack took the life of one of Passaic County's oldest practitioners. Dr. William Hugh Meier, born in 1855, was graduated in 1915 from the Jefferson Medical College. He was a life-long resident of the upper Passaic-Morris county area. Born in Butler, he practiced in Haskell. Dr. Meier was a general practitioner, active in the work of the Bloomingdale (New Jersey) Board of Education. He was, at one time, Health Officer for Wanaque and had a tour of duty in a similar capacity for the Boro of Ringwood. He was Kinnelon's school physician.

DR. JOHN PRESTON MOORE

At the untimely age of 62, Dr. John Preston Moore died after a brief illness on September 21. A 1927 graduate of Meharry Medical College, Dr. Moore interned in Raleigh, North Carolina, and then came to New Jersey a few years later to practice in Burlington. He moved to Newark in 1939 and soon became active in civic affairs. He was chief physician to the Knights of Pythias, and, at the time of his death, was senior physician to the Essex County Jail. Dr. Moore served in the Army during World War I and entered Howard University as an undergraduate in college after his return from military service in 1919.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was called to order by the President, Dr. Josiah C. McCracken, Jr., on October 13.

Dr. Morton Major, Chairman of the Program Committee, explained that a new type of program would be tried at this meeting. Questions of maximum interest would be discussed by a panel. The first topic was social security for physicians. The panel consisted of Doctors Morton Rosenblatt, Benjamin Bacharach, Frederick Panico, and Milton Cutler. They, with many other members, plunged into a lively discussion of social security for physicians. Since the discussion was unexpectedly lengthy, the balance of the program (which was on federal legislation concerning the aged) was deleted. The committee, the chairman, and the panelists were congratulated for presenting such an excellent program.

Dr. Paul Steel, Treasurer, reported that dues this year would total $90. This consists of: $35 state, $5 AMEF, $35 AMA (increased $10 from 1961), and $15 county.

The application of Dr. George Keates for Associate membership was accepted unanimously.

It was pointed out that the Medical Society of Atlantic County is still in favor of fluoridation and since there have been recent articles in the newspapers on this, it was agreed that we make a statement again defining our position.

Dr. McCracken, as the incoming president, made a report which will appear in the *Bulletin*.

A discussion about telephone directory listing was referred to committee.

A resolution concerning Dr. Thomas Petinga was read and approved unanimously. A copy will be sent to the Board of Medical Examiners, State of New Jersey, and to Dr. Perry Frank.

A resolution concerning the Guidance Center, to be sent to the Board of Freeholders, was made, emphasizing the importance of the Guidance Center and the need for additional funds in the 1962 budget.

Dr. Clifford Murray spoke on the proposed Atlantic County Diabetes Society. The Medical Society of Atlantic County approves of this lay organization and a letter will be sent advising that Dr. Clifford Murray and Dr. Victor Bressler will aid in establishing it.

The meeting was closed at 10:55 p.m. and was followed by refreshments.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held Tuesday, October 10 at Bergen Pines Hospital, Paramus, was called to order by Walter Wahrenberger, M.D., President, at 9:05 p.m. Ninety-five members were present. The secretary presented membership certificates and wallet identification cards to the four Active members elected at earlier meetings.

The secretary then read the names of Associate members elected at the June meeting and requested them to arise to acknowledge introduction.

The secretary presented the following applications, which had been recommended by the Membership Committee, approved by the Executive Committee, and cleared by the Credentials Committee of The Medical Society of New Jersey: *To Active from Associate*—John F. Barrett, Bernhard W. Hausheer, Arthur W. Jacoby, William A. Layman, Giulio C. Mondini, Mario L. Pesaresi, Arthur D. Pesin, Jerry Weisberg; *To Active by Transfer*—Vincent Carter, Jr. (From Med. Soc. Co. N.Y.), S. Raymond Gambino (From Med. Soc. of Milwaukee Co.—Wisc.), Charles Henry Hall, Jr. (From Essex Co. Med. Soc.), Theodore J. Medrek (From Norfolk Distr. Med. Soc.—Mass.), Stanley Pogul (From Med. Soc. Co. of N. Y.), Christopher T. Reilly (From Passaic Co. Med. Soc.); *To Courtesy*—William Karl Hass (Member Med. Soc. Co. of N. Y.); To Associate—George Horoshowski, Merle H. Katzman, Jules C. Landenheim, Charles C. McIntosh, Thomas E. Potter, Joseph J. Radest, Osvaldo D. Sabato, Marvin Shuster, James D. Tully, Joseph J. Woehl.

These applicants were then elected to membership.

The treasurer called attention to the financial report printed in the October *Bulletin* and moved its approval. There being no corrections or questions, the report was declared approved and ordered filed for audit.

The treasurer reviewed the report of the Budget Committee as printed in the October *Bulletin* and moved its adoption. Some members asked about the elimination of the annual deposit in the Building Fund and the transfer of the item of $2500 for this year only to the Scholarship Fund. It was explained that this action was recommended on a one-year basis and was not intended to establish a precedent. The treasurer was requested to report at the next meeting on the detailed items totaling $1100 making up the allocation for the Community Service Committee. There being no further comments or questions, the question was called and the motion passed.

The Chair turned the meeting over to Dr. Marshall Driggs, chairman of the Program Committee.

Dr. Driggs presented the speakers of the evening.

Dr. Henry Heimlich, Chief, Esophageal Surgery at the Flower 5th Avenue Hospital, spoke on "The Declining Role of the Physician; What We Can Do About It." At the conclusion of an inspiring talk by Dr. Heimlich, the Society heard from Mr. Edmund Opitz of the Economic Education Foundation. Mr. Opitz spoke on "Threats to the Freedom of the Professions."

At the conclusion of these presentations, the unusual interest of the audience became apparent by the spirited comments and questions from the floor. Points considered included the policy of open hospital staffs, the management of "hospitals by doctors for doctors," and the limiting of the use of an expensive modern medical equipment to those qualified by special training both as a protection to the public and to reduce the cost of today's diagnostic and therapeutic programs.

Both Dr. Driggs and the Chair warmly thanked the speakers for an exceptionally interesting and challenging evening.

CHARLES P. CAMPBELL, M.D.

Reporter

Camden

Fifty-eight members of the *Camden County Medical Society* gathered for a general meeting on October 4, at the Cherry Hill Inn.

Drs. William McDonnell, Edward N. Ludin, Theodore A. Lyras, Frederick W. Millspaugh, James G. Pryor and Thomas L. Singley were sworn to membership; Dr. McDonnell, Active, and the others, Associates.

The evening's guest speaker, Dr. Charles S. Petty, Assistant Chief Medical Examiner of Maryland, told of the groping grimness and gruesome grotesqueries associated with his office. "Definitive Investigation of Death," was the title of his compelling address. He also neatly detailed the differences of the coroner's and examiner's systems.

The business session was devoted largely to a discussion of the proposed budget. The treasurer and his committee prevailed; a hike in County dues was passed unanimously.

Memoirs honoring the late Drs. McWilliams and Dempsey were read and spread upon the minutes.

The nominating committee offered the name of Dr. James E. Brennan for election to the executive committee. He was duly elected and will serve the unexpired term of resignatee Dr. Frank Santor.

Officers elected last May are as follows: Dr. William T. Read, Jr., President; Dr. Elmer L. Grimes, President-Elect; Dr. James R. Eynon, Vice-President; Dr. James G. Dickensheets, Secretary; Dr. Louis G. McAfoos, Jr., Treasurer; Dr. Helen F. Schrack, Historian; Dr. Frederick W. Durham, Reporter.

Camden County has functioned amply with four general meetings a year. Each month there is a meeting of the executive committee, a body of sixteen which includes seven officers and nine elected committeemen representative of various branches of medicine, the hospitals and sectors of the County. These sessions are open to all members.

The approach to handling of affairs in this manner has been successful for the past several years and, although admittedly not without some minor drawbacks, it has enjoyed popularity among the constituency. Programs for the general meeting have attempted to be less of a pure scientific nature and more informative of the ancillary avenues in medicine.

FREDERICK W. DURHAM, M.D.

Reporter

Hudson

With Dr. Nathan J. Plavin presiding, the first regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center on October 3.

The scientific program was a panel discussion on the "Palliative Treatment of Cancer" by the Pa k Medical Group moderated by Dr. George T. Pack. Participants were: Dr. Robert Booher, who spoke on surgical treatment; Dr. Theodore Miller, who discussed radiation therapy; Dr. Samuel Dyoskin, who reviewed hormone therapies; Dr. David W. Molander, who talked on chemotherapy; Dr. Irving Ariel, who discussed isotope therapy; and Dr. John Conley, who talked on cancers of the head and neck.

Drs. John J. Butler and Theodore Kushnick of Seton Hall College of Medicine, were elected to regular Active membership at this meeting.

Following the business meeting, a collation was served.

CHARLES L. CUNNIFF, M.D.

Reporter

Middlesex

Under the chairmanship of Dr. Thomas F. McLaughlin, President, the *Middlesex County Medical Society* held its first meeting of the 1961-1962 year at Roosevelt Hospital, Metuchen, on October 18.

Applications for membership were approved for presentation to the Credentials Committee of the State Medical Society as follows: To Regular membership from two years' Associate membership—Dr. Coralyn Ruth Flad, New Brunswick; Dr. Charles De Liberti, Highland Park. To Regular membership by transfer from the Hudson County Medical Society—Martin Sokalor, Old Bridge. The

application of Dr. Harvey Moser, New York City, was withdrawn by phoned request of applicant. To Honorary membership—Dr. J. F. Weber, formerly of South Amboy.

Dr. McLaughlin then led the Society in silent prayer for departed members Drs. W. H. McCormick and S. Gordon Berkow.

Dr. S. David Miller announced that the Middlesex County Chapter, American Academy of General Practice, has initiated a campaign to have everyone in Middlesex County immunized against tetanus. The Academy will advertise in the local newspapers in an effort to encourage people to go to their family doctor for injections. Our Public Relations Committee was then empowered to act in collaboration with the American Academy of General Practice on this matter.

The financial statement for the past year was read by Dr. Tyrrell, Treasurer, and accepted as read.

On the program for the evening was Mr. Paul O. Koether, Instructor in Investments at Rutgers and Princeton Universities. His talk gave information on why, how and when to invest.

Due to conflict with The Medical Society of New Jersey Annual Convention in May, the regular monthly date of the County Medical Society was postponed to the fourth (4th) Wednesday, or May 23, 1962.

Meeting was adjourned and collation served.

EUGENE L. CHILDERS, M.D.

Reporter

Morris

The first fall meeting of the *Morris County Medical* Society was held on October 19 at the Warner Lambert Laboratories in Morris Plains. This initiated the new policy of intermixing non-medical subjects with medical lectures during the coming year. Mr. C. L. Chambers of New York City, an expert on estate planning, discussed some of the ramifications of this timely and important subject. A lively question and answer period followed. Interestingly, this non-medical topic brought out the largest attendance in recent years.

The business meeting which followed emphasized (1) the Medical Student Loan Fund which is now functioning and awaiting applicants, and (2) a report from the Public Relations Committee discussing plans for a series of radio program and newspaper coverage to bring more understanding between the public and the profession at the county level.

Dr. Dexter Blake, President, adjourned the meeting at 11:00 p.m., and collation followed.

MONROE H. MUFSON, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on September 26, at the Medical Society Building. Dr. David B. Levine, president, officiated.

The following were elected to Associate membership: Drs. S. William Ries and Arthur G. Ship of Paterson and Joseph A. Ferrante, Jr. of Clifton. Elected to Active membership by transfer were Dr. J. Allen Yager of Paterson and Dr. George Popp of Passaic.

Dr. Levine read a resolution on the death of Dr. Burt W. Botbyl, which was unanimously adopted.

The president called upon Dr. Peter G. Berkhout, Chairman of the General Practice Committee. Dr. Berkhout advised the members to enlighten the public on the necessity of both influenza and tetanus immunizations. He also reported that we have at the Society office excellent brochures on influenza immunization and active immunization against tetanus. These pamphlets are available to the doctor for use in his office.

Dr. Levine then introduced Dr. Edward Wolfson, Program Chairman, who presented the speaker for the evening, Mr. Gilbert S. Carpenter, Chairman of the Board, Carpenter, Matthews and Stewart, Inc. Mr. Carpenter spoke on "The Practice of Public Relations in Medicine." A question and answer period followed.

At the conclusion of the program, a collation was served by Mrs. David B. Levine, Chairman of the Hospitality Committee of the Woman's Auxiliary.

ALEX E. SCHEFRIN, M.D.

Reporter

Salem

The October meeting of the *Salem County Medical Society* was called to order at 4:45 p.m. in the Woodstown Diner by the President, Dr. William Sprout. Present were 24 Active members and 2 Associate members.

Dr. McLean announced that Blue Cross dues for society members are due before December 1, 1961. The amount is $103.32 and checks are to be made out to the Salem County Medical Society.

Dr. Harry Suter urged all members to send retarded patients to the newly-formed unit for Retarded Children in Pennsville, N. J. Maximum charge per month is $30. Ages of patients are to be in range of 4 to 8 years.

The proposed changes in the County Society by-laws were read then by the president. After a brief discussion, Dr. Gilpatrick moved that the pertinent amendments be adopted as read. The amendments passed unaminously.

Dr. Sprout then told of the new test for diagnosing streptococcal infections via fluorescent anti-

body technic. The State Health Department is interested in setting up such a program in South Jersey. All interested are asked to communicate their feelings to Dr. Palmer of the Southern Health District at Haddonfield.

Dr. Staub introduced guest speaker, Sanford Rogg, M.D., Attending psychiatrist at Dupont's Chemical Works. Dr. Rogg spoke on the Salem County Guidance Center, its history, functions, patient types and expenditures.

After a lively question and answer period, the meeting adjourned at 6:15 p.m.

JOHN T. DOOLEY, M.D.

Reporter

Book Reviews • • •

One for a Man; Two for a Horse. By Gerald Carson. Garden City, N. Y. 1961. Doubleday. Pp. 128 with 500 illustrations. ($6.50)

Your waiting room table is the place for this remarkable atlas. It is a nostalgic but accurate pictorial review of patent medicine advertising in the last half of the nineteenth century and its carry over up to Hadacol of the last decade. Any physician born in the nineteenth century will recall the gorgeous, highly colored, fabulous and utterly dishonest patent medicine advertising that disfigured grandpa's day. This book shows the advertising brochures, posters and cartoons that accompanied such promotion. It is a great tribute to the indestructibility of the human frame, that so many Americans survived. It is all here: the electrical belts, the bust developers, the consumption cures, the saccharine testimonials, the treatments for impotence and female weakness: Peruna and Lydia Pinkhams, Kickapoo Juice, Swamproot, Nuxated Iron, Carter's Little Liver Pills, Cascarcts, and the whole parade of flamboyant, boastful, and picturesque advertising. Physicians in the mid-nineteenth century were often poorly educated; and indeed, medicine had little to offer. Doctors were widely scattered and self-medication was a necessity. The country was big, self-confident, wealthy and growing fast. So, perhaps this dizzy era of advertising extravagance can be understood in social and historical terms.

Many of the illustrations are unique. All are interesting. The text is brief, readable and to the point. To those of us worried about the allegedly declining image of the physician, this atlas should be a tonic. Things not only could be worse: not so long ago, they *were* worse. The book is a conversation piece that will rouse memories in the old and astonishment in the young.

ULYSSES M. FRANK, M.D.

A Syllabus of Medical History. By Fred B. Rogers, M.D. Baltimore 1960. The Waverly Press. Pp. 34. ($2.00)

At Temple University a course in medical history is given annually by Dr. Rogers, archivist to our Medical Society. This slim, hard-bound book represents the syllabus for the course. The book is printed on the *recto* pages only, the *verso* pages being left blank for notes. The book is flavored with many old drawings that convey the scent of medieval and ancient medicine. A number of useful tabulations (such as Nobel laureates in medicine) are also included. While not offered as a definitive text, this is a valuable note-book for the student or practitioner proud of his heritage.

HENRY A. DAVIDSON, M.D.

Manual of Care for the Disabled. A. J. Heather, M.D. New York, 1960. Macmillan. Pp. 119. ($3.75)

In this brief book, Dr. Heather has compressed one of the most practical volumes this reviewer has ever seen. It describes the care of patients who need bowel training, prosthesis, urinary control, and similar facilities. The text is intensely practical. Thus, in describing care for the hemiplegic, Dr. Heather spells out details of oxygen therapy in the acute stage (how to avoid irritating the nose or the development of lipoid pneumonia; how to regulate the valves) and—for the chronic

phase—such problems as bowel and bladder control, positioning of the patient, prevention of contractures and bed sores, and so on.

A number of charts are included which serve both as guide-lines and as check lists. There are special chapters on the arthritides, osteoporosis and the nutritional problems of the disabled. This compact book will be of daily use to bedside nurses; and it stands by as a clear reference work for physicians who are expected to know these practical little pointers, as well as the theory of chronic illness.

VICTOR HUBERMAN, M.D.

The Psychology of Crime. David Abrahamsen, M.D. New York 1960. Columbia University Press. Pp. 358. ($6.00)

One of the great puzzles of life is what makes people criminals. In this meaty volume, Dr. Abrahamsen develops the thesis that antisocial inclinations develop out of family tensions; and that criminal acts occur when these tensions, aggravated by precipitating events and colored by an unconscious wish for punishment, are drained out through the aggressiveness that results from insecurity. He defends this thesis with well-grounded reasoning and salts it with numerous case reports. The book includes an interesting and compact historical background reflecting changing attitudes about the cause and management of criminal behavior.

Dr. Abrahamsen believes that competition creates a climate favorable to crime. He fears that our prosperous culture has overemphasized the material side of life, and offers tremendous self-satisfactions to the criminal. The author offers some interesting material on psychosomatic, neurologic and electroencephalographic findings among chronic criminals. Much of his material is controversial, a fact which lends piquancy to the book. Dr. Abrahamsen defends his theses with vigor and skill; and this stimulating text may lead to a much needed reappraisal of our thinking about criminal behavior.

HERBERT BOEHM, M.D.

Oncogenic Viruses. By Ludwik Gross. New York, 1961. Pergamon Press. Pp. 300. ($12.00)

This is a scholarly and historical monograph on the animal viruses. It covers the lesions in rabbits, dogs, cattle, frogs and chickens which have been shown to originate in a transmissible virus. The greater portion of the volume deals with mouse leukemia and mouse parotid tumors. There is also an excellent historical review of Rous chicken sarcoma. This book is exceptionally readable and it was a distinct pleasure to review it. The reader will be impressed with the author's ability as a scholar in the field of virology as well as his sensitive appreciation of the historical aspects of medical virology. Photographs of the leaders in the study of oncogenic viruses are included in the volume. The book is timely, historically delightful, and should be required reading for all senior medical students as well as members of both the medical profession and the general public who wish to be conversant with the tumor problem.

Dr. Gross gives his own concept of how profound studies of oncogenic virology in animals can be translated and applied to the etiology of tumors in humans. His opinions echo a full appreciation of the impossibility of the task, but he certainly establishes a "working hypothesis."

This volume should earn for its author a *cum laude* from the medical and scientific world.

THOMAS K. RATHMELL, M.D.

Memoirs of a Medico. By Dr. E. Martinez Alonso. Garden City, New York, 1961. Doubleday. Pp. 335. ($4.50)

Described on the jacket as "the personal story of an adventurous doctor whose practice has ranged from battlefields to luxury hotels," this autobiography ranges from the savage butchery of the Spanish Civil War to the gaiety and leisure of the international smart set. Dr. Alonso, currently a hotel physician in Madrid, is a skilled raconteur whose romantic anecdotes are told with charm and zest. A Latin temperament, quixotic humor, and eye for drama and the unusual permit no dull moments in this swashbuckling narrative.

Son of a wealthy diplomat, Alonso grew up in Spain and Scotland. After taking his medical education at Liverpool University in England and serving briefly aboard a freighter, he returned to Spain and was soon in the thick of strife. As commander of a front-line surgical unit and later a base hospital, he witnessed first-hand the devastation of civil war. Busy firing squads were one part of the terror he saw between 1936 and 1939. However, Dr. Alonso survived. No matter how he falls, he lands on his feet.

During World War II, the author served for a while at a military hospital in England. Returning to Spain in 1946, he became a doctor for a plush hotel in Madrid: a position which has provided him with many amusing and unusual anecdotes and brought friendship with a number of celebrities.

Nothing human is alien to this "medico" whose years have been extraordinarily full of adventure and challenge. A shrewd observer, Dr. Alonso tells much about life and living to the reader of these zany memoirs—which are dedicated to his daughters, Billie and Patricia. A literary verve and flamenco flavor make this varied account interesting reading at bedtime or any time.

FRED B. ROGERS, M.D.

Cardiopericardiomyopexy. Dr. Aaron N. Gorelik. New York, 1961. Myopexy Association, 250 W. 57th Street. Pp. 176, illus. ($5.00)

In view of its frequency as a primary cause of death in man, coronary artery insufficiency and occlusion has been the subject of a great deal of clinical and experimental investigation. Numerous operative procedures have been proposed to increase the blood supply to the myocardium. These procedures are based on the thesis that irritation of the epicardium produces adhesions with subsequent collateral circulation. Technical simplicity and easy availability of case material has given this theory sufficient opportunity to prove its merit; but we have no convincing evidence that this procedure has any prophylactic or curative value. The book *"Cardiopericardiomyopexy"* published by "The Myopexy Association Inc.," consists of discussion of this operative procedure and its indications. Several chapters are devoted to non-coronary type of cardiac pathology for which, amazingly enough, this procedure is advised! These chapters are poorly organized and the subject matter inadequately dealt with.

This reviewer feels that if the aim of "The Myopexy Association Inc." is to improve the lot of the sufferers of heart disease, as its motto implies, they would do better by supporting and endorsing the already recognized organizations, such as The American Heart Association and promoting its scientific publications. I find nothing in this book which could be of use to the profession or the public.

ADRIAN M. SABETY, M.D.

The Golden Age Cookbook. By Phyllis MacDonald. New York, 1961. Doubleday. Pp. 192. ($2.95)

The publishers of this book claim this to be "the first and only cookbook designed especially for people of retiring age." This is far from the truth. It differs very little, if at all, from the hundreds of cookbooks on the market. The author is a capable home economist or dietitian. Her remarks on nutrition are sound and up-to-date; but she has added nothing new either for the aged group or any group which has not already been repeated by every writer on foods and nutrition in books, magazines, and newspapers.

By the time a woman has been cooking for 35 or 40 years her menus are pretty well established. To give her directions for changing over from the veal chops "that mother used to make" which tasted so good, to baked parmesan veal chops, or instead of having bananas and cream to switch over to banana cocoanut crisps (which contain bananas, light cream, cornflake crumbs, sugar, cinnamon, butter, lemon juice, and shredded cocoanut) only means more work and more shopping; and consumes more table money.

The menus in the chapter for a "Fellow Who Lives Alone . . . " he just couldn't make a go of it. Before he tried to make the recommended Chicken Tetrazini (spaghetti, cooked chicken with orange sauce, cream of chicken soup, milk, instant minced onions, grated cheddar cheese, parsley flakes, and Worcestershire sauce) it would be more prudent for him to marry a cook with a Home Economics degree.

Miss MacDonald is making it tougher—not easier—for the old folks.

S. W. KALB, M.D.

Management of Obstetric Difficulties. Revised by J. Robert Willson, M.D. St. Louis, 1961. Mosby. Pp. 687. 6th edition. ($16.50)

This is the sixth edition of a text which has come to be relied upon by many obstetricians and residents because of its brevity, "matter-of-factness," and scope. It is not a text for the generalist or medical student because it presupposes much basic knowledge of this specialty.

Dr. Willson neatly catalogs the many obstetric difficulties. Beginning with the worst obstetrical tragedy—infertility—and ending with the finished product—the newborn—most of the field is covered. In the section on infertility, the reader is left somewhat hungry because the "pat answers" in therapy are not there. But, then, are they anywhere?

The author uses proprietary names for many medications. This may make the book seem prematurely outmoded. Generic names might be preferable since their nuances can be uncovered quickly by any interested party.

Startling revelations are rare in any text but this one provides some. That cytologic studies have uncovered one cervical cancer in every 2000 Caucasian patients screened during pregnancy, and a much higher number in a "clinic group" at Temple, gives us all cause to sit back and reflect. We are not screening women early enough! The Papanicolaou smear has now become of equal importance to, if not more important than, the serologic test in the prenatal work-up.

A text which presumes to cover a field as broad as this does, must run into the problem of brevity to the point of extinction and this is true in several clinical areas such as the superficial discussion of chronic glomerulonephritis in pregnancy, and cardiac surgery in pregnancy. This is compensated by the excellent discussion of diabetes in pregnancy, including the prediabetic mother. One notes with regret, however, that there is no mention of placental insufficiency except for one notation under the general topic of postmaturity.

This text still ranks with the leaders in the field of obstetrics and belongs on the shelf of specialists in training or practice.

EUGENE J. SLOWINSKI, M.D.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Index 1961

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 58

JANUARY TO DECEMBER, 1961

Published monthly under direction of the
COMMITTEE ON PUBLICATION

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† Obituary
e—Editorial
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ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

DECEMBER, 1961 ● VOL. XXXIV, NO. 10

OBSERVATIONS ON EXCESS MORTALITY ASSOCIATED WITH EPIDEMIC INFLUENZA

Two epidemics of Asian influenza since 1957 have resulted in 86,000 excess deaths. High-risk groups are those 65 years of age and over, persons with certain chronic diseases, and pregnant women. Immunization is suggested for these groups.

One of the classic epidemiologic descriptions frequently applied to influenza is embodied in the phrase "high morbidity, low mortality." Such a description, however, tends to lose sight of the fact that morbidity in epidemic influenza may be so high that even the relatively low associated mortality may itself reach grave proportions.

Two epidemics of Asian strain influenza have occurred in the United States since the identification of this antigenic variant in May, 1957. The first occurred in two distinct waves from September through December, 1957, and from January through March, 1958; a total of almost 40,000 excess deaths was recorded during the first wave and of 20,000 during the second wave. During the first three months of 1960 a second major epidemic occurred, resulting in approximately 27,000 excess deaths. A total of 86,000 deaths in excess of the expected number thus occurred in the United States as a result of Asian influenza epidemics in the three-year period.

It is important to determine in how many of the 86,000 excess deaths influenza was merely a terminal event in an already severely debilitated patient, and in how many influenza and its accompanying pneumonia may have killed a person in active, productive life, albeit in an older age group, or with definite but compensated chronic disease.

THEODORE C. EICKHOFF, M.D.; IDA L. SHERMAN, M.S., and ROBERT E. SERFLING, PH.D., *The Journal of The American Medical Association*, June 3, 1961.

The best measure of the total impact of an epidemic is provided by the total excess mortality. The following table shows the estimated excess, and that the bulk of it was in deaths due to pneumonia-influenza and cardiovascular-renal causes:

Cause and Period	Expected	Observed	Excess
Oct.-Dec., 1957			
Total Deaths	408,320	447,620	39,300
Pneumonia-influenza	12,440	24,540	12,100
Cardiovascular-renal	221,360	240,060	18,700
All other	174,520	183,020	8,500
January-March, 1958			
Total Deaths	421,020	441,020	20,000
Pneumonia-influenza	16,740	22,740	6,000
Cardiovascular-renal	235,180	248,180	13,000
All other	169,100	170,100	1,000
January-March, 1960			
Total Deaths	439,100	465,800	26,700
Pneumonia-influenza	18,270	28,870	10,600
Cardiovascular-renal	246,350	258,550	12,200
All other	174,480	178,380	3,900

When excess mortality data are analyzed by age, it is apparent that the heaviest toll is paid by the population over 65 years. Although during the first epidemic period only slightly over one half of the excess deaths occurred in persons 65 years and older, this proportion increased in succeeding epidemics; in the 1960 epidemic, 80 per cent of the excess deaths occurred among individuals in this age group.

It need not seem paradoxical that an epidemic of influenza should cause a distinct wave of excess deaths said to be due to cardiovascular-renal disease, or to some condition other than influenza or pneumonia. These "epidemics" of chronic disease are because deaths in the United States, as well as in most other countries, are tabulated by "primary" cause, that is, the cause that initiated the train of circumstances which eventually resulted in death.

LIVES CUT SHORT

Analysis of the excess mortality data has suggested that most victims of an influenza epidemic are those who might have lived considerably longer had influenza not claimed them, rather than severely debilitated patients in whom influenza is simply the terminal event.

Excess influenza-associated deaths due to asthma, diseases of the respiratory system other than influenza and pneumonia, and pulmonary tuberculosis probably occur primarily in patients whose pulmonary function is significantly compromised. The lives of diabetics are jeopardized by influenza not only by their increased risk of bacterial superinfection and increased incidence of cardiovascular-renal disease, but also by the increased risk of acidosis and coma during an acute infection.

An increased risk in influenza death in association with certain conditions is better demonstrated by clinical studies than by analysis of reported mortality data. The association of rheumatic heart disease and influenza-associated death, particularly rheumatic mitral stenosis and fatal influenza-virus pneumonia, for example, is well documented in the literature.

A relationship between influenza-associated deaths and pregnancy is a common clinical impression. Several studies carried out during the 1957 pandemic have indicated that pregnant women are definitely at greater risk of death from influenza than non-pregnant women of the same age group.

VACCINATION FOR HIGH-RISK GROUPS

There is a significant body of evidence that the lethal potential of epidemic influenza is still present. Rather than recurring in a mild form, as might have been anticipated as the over-all immunity of the population increased, the most recent outbreak in 1960 resulted in excess mortality which exceeded that of the second wave of the 1957-1958 epidemic and approached that of the first wave.

This analysis serves to underscore the fact that certain individuals are at increased risk of death from influenza. Three broad groups can be identified—persons over 65, persons with certain associated chronic diseases, and pregnant women. The chronic illnesses of significance include cardiovascular-renal disease, particularly rheumatic heart disease; chronic pulmonary disease, e.g., bronchial asthma and pulmonary tuberculosis; and metabolic diseases such as diabetes mellitus.

It would seem entirely reasonable to believe that the prevention of influenza in these high-risk groups would result in a corresponding reduction of excess influenza-associated mortality. Annual immunization of such high-risk groups against influenza might well be highly effective in reducing the disquieting toll of excess deaths periodically exacted by epidemic influenza.

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Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton 5, New Jersey.

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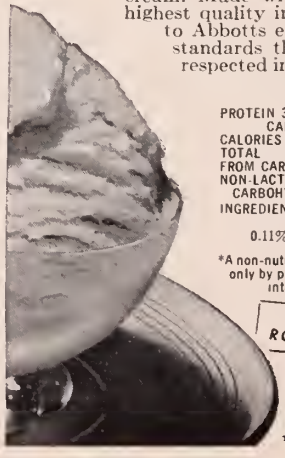
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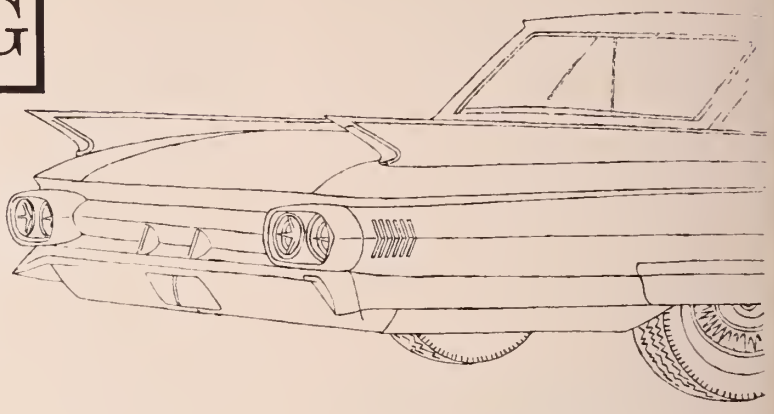
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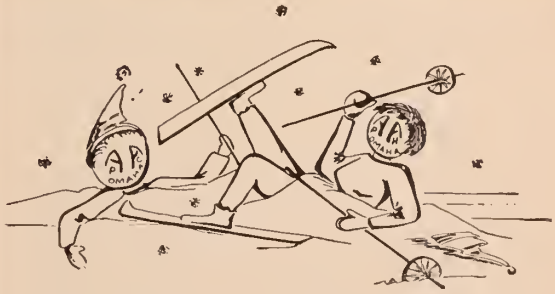


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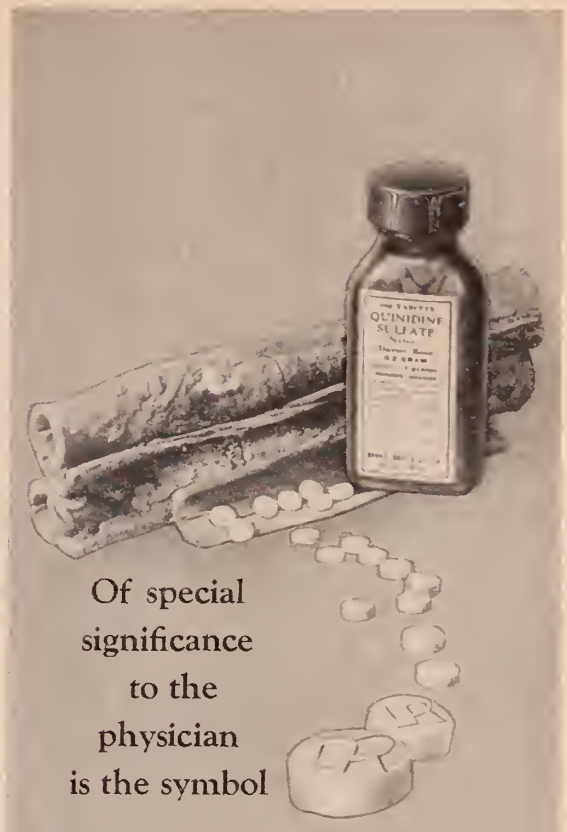
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Bibliography: (1) Jacobs, L.: GP *21*:93 (Jan.) 1960. (2) Shulman, L.: J.A.M.A. *175*:118-123 (Jan 14) 1961. (3) Moore, C. V., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, p. 213.

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